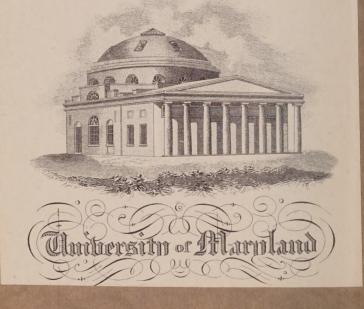
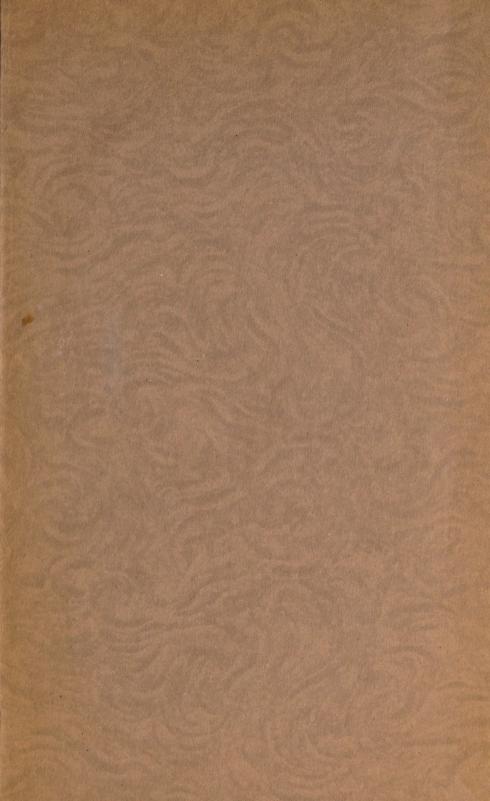
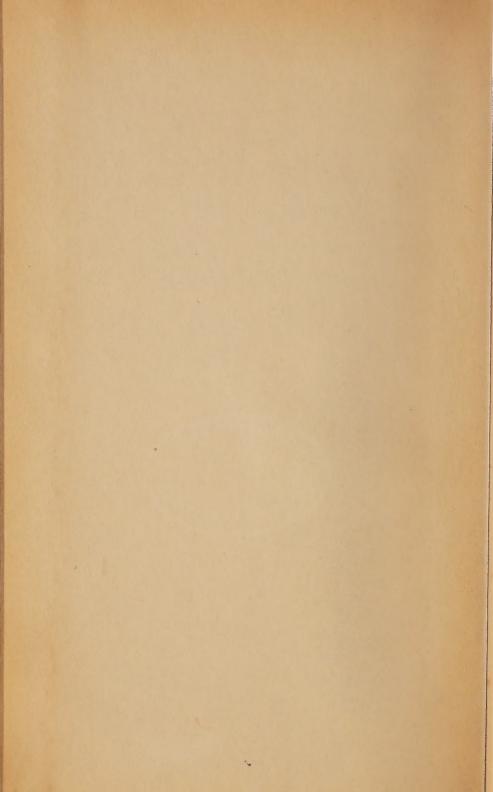


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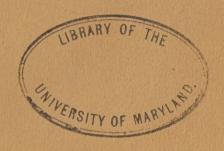
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BALTIMORE.

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APRIL, 1910

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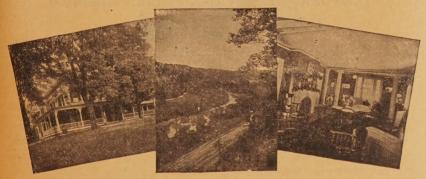
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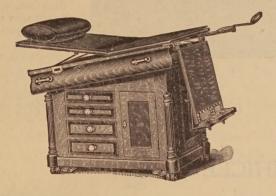
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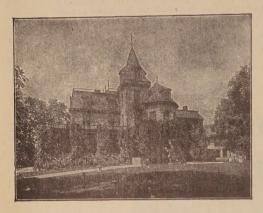
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## THE JOURNAL

### OF THE ALUMNI ASSOCIATION

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## COLLEGE OF PHYSICIANS AND SURGEONS,

### BALTIMORE.

REPORT OF A CASE OF GALL-STONES.\*
By DR. J. E. RADER, HUNTINGTON, W. VA., '94.

Mrs. D., married, 62 years old, previous history negative, with the exception that about one month prior to this, she had an attack of cramplike pains, radiating over abdomen, accompanied by nausea and vomiting, and localizing in right iliac fossa, which left a tenderness in this region for two or three days, gradually disappearing, only to return again on the 10th of September, 1908, when I was again called to see her about 9 o'clock p. m. I found her suffering with severe pain, again radiating over abdomen, but not localized in any particular region. Tongue furred, nausea and vomiting, bowels constipated, temperature 100, pulse 85, right rectus muscle very rigid and extremely tender on pressure. Patient had taken previous to my arrival a dose of sulphate of magnesia, which in due time acted very satisfactorily. Contrary to my usual line of treatment in such cases, I gave her morphia sulph. gr. ¼ and atropia sulph. gr. 1/150 hypodermatically, which relieved her in about 20 minutes, and applied ice cap over right iliac fossa.

September 11, 10 a. m.; patient slept very well the greater portion of the night. Condition very much the same as when I left her the previous night, except she was not suffering any pain and there was no nausea or vomiting, but complained of being very sore, tenderness and rigidity of right rectus more marked.

At 9 a. m., same day, patient restless and complaining of slight pain over region of appendix, very tender on pressure in right lumbar and right iliac regions; temperature 100.

<sup>\*</sup> Read at Annual Meeting State Med. Ass'n, at Elkins, October, 1909.

September 12, 9 a.m.; patient passed a very restless night, suffering some pain, otherwise condition very much the same, tenderness and rigidity more marked; temperature 100.6. Operation advised.

9 p. m.; patient complaining of being very sore; tenderness and rigidity of right rectus so marked as to make deep pressure almost, if not quite, impossible; temperature 101.

September 13, 9 a. m.; patient had a very comfortable night, did not complain of any pain except when moved. Tumor mass, which could be easily made out, extending down below McBurney's point; temperature 101.6.

9 p. m.; patient in very much same condition as in the forenoon, except a little more restless and a somewhat anxious expression. Tumor increased in size.

September 14, 9 a. m.; patient had a very restless night, temperature 101.6, tumor larger than on yesterday, tenderness more marked; family and friends finally consent to operation.

1 p. m., removed to hospital. 2 p. m., operation; 2-inch incision was made almost directly over McBurney's point, as this was the most prominent part of the tumor; dissecting down to the peritoneum, which was opened. I discovered a greatly distended and inflamed gall bladder, which on introducing an aspirating needle was found to contain a quantity of serum and mucus, with some pus, and almost ready to rupture. After packing off the abdominal cavity with sterile gauze, the gall bladder was opened and found to contain, in addition to serum, mucus and pus, an enormous number of gall stones, from the size of a millet seed to a hazelnut. The number saved aside from several hundred (estimated at 1000), which made good their escape, amongst the dressings, in the basin and on the floor, was, by actual count, 2983, which added to the 1000 that made their escape brings the actual number of gall stones removed to 4000 minus 17 stones.

After removing the stones and irrigating the gall bladder with normal saline solution, the incision was extended upward and the gall bladder anchored with No. 2 catgut to the parietal peritoneum and transversalis fascia. A No. 14 soft rubber catheter was introduced into the gall bladder for drainage, and held in place by a safety pin attached to dressings. The peritoneum and fascia were closed on each side of drainage tube and in-

cision in skin left well open and packed with sterile gauze. The postoperative treatment consisted in irrigating the gall bladder every day for a few days, and then every second or third day for three weeks, with normal saline solution. Patient left hospital in three weeks from time of operation and the opening in the gall bladder was allowed to close spontaneously, which it did completely in the course of about two or three months.

In reply to a letter sent to a number of prominent American and English surgeons, as regards the number of gall stones removed at any one time, the following replies have been received:

George Ben Johnson, Richmond, Va., 500.

A. Murat Willis, Richmond, Va., 365.

W. L. Rodman, Philadelphia, Pa., 970.

J. Garland Sherrill, Louisville, Ky., 600.

H. R. Wharton, Philadelphia, Pa., 240.

W. W. Keen, Philadelphia, Pa., 301.

A. J. Ochsner, Chicago, Ill., 6780.

H. H. Grant, Louisville, Ky., 254.

H. L. Burrill, Boston, Mass., several hundred.

William J. Means, Columbus, Ohio, 700.

David Todd Gilliam, Columbus, O., 366.

Louis Frank, Louisville, Ky., 1040.

Joseph A. Robertson, New York City:

Dr. Moynihan, 2700.

Dr. Frerichs, 1950. Dr. Dunlop, 2011.

Dr. Morgagni, 3000.

Dr. Hoffman, 3646.

Dr. Langenbach, 4000.

Dr. Naunyn, 5000.

Dr. Otto, 7802.

J. Shelton Horsley, Richmond, Va., 474. Joseph Price, Philadelphia, Pa., 1400. Edwin Ricketts, Cincinnati, O., 87.

J. F. Baldwin, Columbus, O., over 4000.

Carl Beck, New York City, 1700.

B. Merrill Ricketts, Cincinnati, O., 923.

Alex. Hugh Ferguson, Chicago, Ill., over 2000.

J. M. T. Finney, Baltimore, Md., over 600.

Roswell Park, Buffalo, N. Y., 3000.

J. W. Chambers, Baltimore, Md., 1159.

William F. Metcalf, Detroit, Mich., 978.

W. J. Mayo, Rochester, Minn., 5000.

E. E. Montgomery, Philadelphia, Pa., 331.

J. F. Binnie, Kansas City, Mo.: "I have found them in number 'like the sands of the sea for multitude.'"

Charles F. Bevan, Baltimore, Md., 160.

S. J. Mixter, Boston, Mass., 40,000.

Maurice H. Richardson, Boston, Mass., 950.

Stewart McGuire, Richmond, Va., 562.

J. Chalmers DaCosta, Philadelphia, Pa., 300.

Omar Pancoast, Baltimore, Md., 1050.

Willy Meyer, New York City, over 400.

Robert T. Morris, New York City, several hundred.

Russell S. Fowler, Brooklyn, N. Y., 450.

H. J. Boldt, New York City., 286.

W. S. Gardner, Baltimore, Md., 750.

George W. Crile, Cleveland, O., 1500.

John C. Munro, Boston, Mass., 1000.

B. Moynihan, 33 Park Square, Leeds, Eng. In one case over 7000 from the gall bladder; in another over 3000 from the common duct.

J. Bland Sutton, 47 Brook St., Grosvenor Square, West, London, Eng., over

# PREPARATION OF THE SURGEON.\* By DR. HARVEY P. JACK, CANISTEO, N. Y.

For the past few years I have held some ideas regarding the training of surgeons to which I here propose to give expression. To one who observes at all it must be evident that there are conditions and abuses about us and all around us which, if not corrected by surgeons themselves, will be soon most vigorously corrected by the public.

In Boston Maurice Richardson and Jas. G. Mumford and Burrell have given vigorous expression to their thoughts upon this subject, and denounced the abuses they have observed in the strongest language. The Council on Medical Education of the American Medical Association is doing its best to raise the standard of the schools, but it seems to me we must go further than this; that each individual surgeon must be brought to see his responsibility in this respect and exercise his individual initiative in seeing to it that only men who are prepared to operate are allowed to operate, and, throwing all jealousies aside, must unite in raising the standard of practical qualifications as well as of theoretical qualifications necessary to advance the art of surgery and render it more and more efficient for the attainment of these great ends.

<sup>\*</sup>Read at the seventeenth annual meeting of the Association of Eric Railroad Surgeons, held at Buffalo, October 7-8, 1908.

We must enforce it upon the schools that they shall send us men as graduates who can do something more than pass and pose—men who can think and do—and who show at least a reasonable probability that in years to come they might develop into practical, conscientious, trained surgical handicraftsmen.

It is only too true that in many hospitals men are allowed to wield the scalpel in a delicate major surgical operation who have not skill or manual training or art or natural aptitude sufficient to entitle them to a union card in a barber's union. Munro says "that to place the responsibility of a major surgical operation upon a young surgeon with the experience of a few months is fundamentally wrong while occasionally criminal."

These conditions are all too prevalent. What can we as surgeons not connected with schools do toward their betterment? Individually we can aid the schools by helping them to secure the best material from among the young men who express to us their ambition, and by discouraging those whom we know to be poor material. Judged from the standpoint of character more than from that of education, a namby-pamby or a dignified mollycoddle does not make the best student or practitioner of medicine or surgery. Above all, is he honest, is he frank, is he courageous, is he conscientious, has he education, common sense, natural aptitude and originality? If he has all of these, he approaches very closely to genius. Is he dishonest, is he a time-server or a mental slave, evasive in his answers to questions, afraid to stand for his convictions or express his honest thought, is he weak and conceited? Discourage such a man with all the arguments you can summon, for while he may attain some success in other walks of life, in this profession he becomes a criminal, and it is criminal to encourage him, either as a student or practitioner. This much the schools have a right to demand from us as practitioners, and this much we must render. This sentiment must be aroused and remain so among surgeons.

Individually we can do this. Collectively we can demand of the schools better and more practical training of the men they enroll—better and stronger teachers. I recently asked a prominent practitioner what he regarded as the most essential characteristic of the successful surgeon. His reply was "originality."

Is it not true that this very characteristic often hinders the promotion

of the very man who should be advanced in medical teaching? Too often this is true of medical teachers that they promote the man to follow in their footsteps because he is a nice fellow and agrees always with them. The man who dares to think and express his thoughts jars on their sensitive nerves, and a weakling receives the position. Gentlemen, we have too many dignified echoes teaching medicine, too many men in a mental rut, and I believe it was an idea something like this that inspired Dr. Osler to advocate the circuit plan, the frequent changing of teachers, and the introduction of new blood.

There are too many unqualified mediocre men teaching medicine who are at it not for love of the work, but for what money or what reputation they may get out of it. They have too often received their promotion, not by reason of force and originality, but because of lack of it; not from fitness, but from politics; not from work well done, but from a pull.

We need and must demand a supervision of medical education, a superintendency that shall look after the standard of the teacher as well as that of the student, a superintendency that shall see that fitness and capability bring promotion, that originality of thought and effort is encouraged, and that ability to teach, trained teaching ability and not pull, shall be the *sine* qua non of acceptance.

The history of medicine, both past and present, shows that nearly all of the really great paths of progress have been blazed by men outside the schools. From the operation of McDowell, in the little Kentucky town, to the operations of Sims, in the little Georgia town, to the work done today in the little Minnesota town, we have ever been obligated to men outside the schools. The man of great originality or great genius is not always, not even most frequently, found in the schools. Lack of personal instruction is the greatest fault of the schools to-day. Says Simon Marx, in speaking of the training for obstetrics: "Of 379 candidates the largest number conditioned was in obstetrics. Out of this number forty-six were rejected. This reflects seriously upon their teaching and nothing else. If young doctors start off in life with this handicap, what in God's name are we to expect of them as practical men? There is something rotten in Denmark."

The days of the preceptor seem to be over. The young man goes to a college in which each laboratory teacher, often due to lack of a concrete

education, impresses upon him that his subject is the only important one, and he graduates usually with narrow, often impractical views of things medical. Of this Friedrich Mueller, the great German internist, says: "As a professor of clinical medicine, I hold the opinion that an observation made at the bedside is as well to be considered scientific as an observation made on an animal. Nor do I think that because it is unable to speak the rabbit is a more scientific animal than man."

Now all over this great country, in hamlets and cities and towns, are known to be hundreds of good practical men well trained and doing good scientific work. A proper supervision would soon make known these. Would it not be a sensible thing to do to arrange to send one or two of these young students to each man, supervise the work, and ask him and pay him for giving one year's practice, all-round personal instruction, to the student. Say, let the student so spend his third year, at the same time keeping up his study and afterwards taking his year's interneship.

To me this plan seems ideal, and I believe it can and will be worked out in time, and will prove a great benefit to both instructor and student. To me it has seemed, and I venture the same is true within the experience of many within the sound of my voice, that nothing has ever or can ever take the place of the instruction received from a good preceptor.

A graduate now, he is not yet a surgeon, nor do I know that he ever will be. If he aspires to be, one of two courses is open to him. Should he be one of the fortunate ones to be selected by the chief of clinic as his assistant—and right here the natural aptitude, the honesty and originality of the man should weigh more than his examination paper in such a selection, and I believe it does in our best institutions—he begins an apprenticeship that should last from three to five years. After that time, if he had aptitude and ability to start with, he is a surgeon. But passing, posing, pull and politics must be eliminated as determining factors in his selection in the beginning.

To this end no amount of care in selecting the recruit for this great handicraft is too great. I do not believe a four years' college course is necessary or desirable for the best results. Too often this results in oversophistication. The man sees things from so many sides that all sides are dim to him, and he has few real convictions or clear original conceptions. One of the greatest men that ever lived said that a college education

polishes stones and dims diamonds. The world's history, as well as the history of our profession, shows that this is true. Ample education is sufficient; a year in college with a good high school education is the standard the world over for entering this profession, and experience proves that it is sufficient, and that more is more often a damage than a benefit.

The development of most surgeons must take place in another way, after his graduation, and among these are the greatest discoverers and originators the world has known. After graduation a few years is spent in practice, and the bent of mind and aptitude are self-discovered. Now, our man will do one of two things: He will either attempt to practice major surgery at once or will take special courses to qualify himself. In the former case he is criminal, if not a criminal. The country is infested with two classes of men in this respect—the recent graduate who imagines he can do any operation, and the amateur doctor who, as Munro says, operates for the excitement or the fee. Both classes should be equally condemned and restrained. The conscienceless man who will do this deserves the severest punishment, and Maurice Richardson thinks a healthy malpractice suit is the only way to reach him. The curse of the smaller hospitals, especially the small private hospitals, is this class of men, and if we do not restrain them by a healthy surgical public sentiment, the public will soon rightly conclude, in the great State of New York, where we are doing so much governing by commissions, that public safety can only be secured by a supervising commission. I am not sure it would not be the best thing.

The man who takes his special courses and has conscience, aptitude and originality, will, if he trains his hands as well as his head, have a good chance to become a competent surgeon and a credit to his profession. This training of the hands is a sine qua non. Some men never can become surgeons any more than some can become musicians or artists. The best man in this respect is, of course, the one born with natural aptitude. We must insist that our schools giving post-graduate work have a department for training men to express themselves with their hands. The ordinary courses in operative surgery are not enough. The man must be trained to use his hand with the delicacy of a woman or the strength of a man. Carstens suggests that students of operative surgery be given dressmakers'

materials and thoroughly learn to sew and cut and fit. The suggestion seems to me excellent.

These conditions are just as prevalent in Europe as in this country. American surgical technic, American surgery is the best in the world today. As Bevan says, "we have the best medical schools and the worst." As our laws and standards become more uniform and each State or the general government shows more interest in medical matters, and we get from it or them the support we deserve, the United States is swinging into line to lead the world in science and invention as well as in finance.

# THE COMMERCIAL VALUE OF AN EARLY AND CORRECT DIAGNOSIS.\*

BY DR. WILLIAM J. TODD, MT. WASHINGTON, MD.

A young man, a cadet in one of the military colleges near Baltimore, came home to spend the holidays. He brought with him two of his friends, cadets from the same college; the matron of the college, a friend of the family, also came to his father's house. In addition to these four visitors in this household were a youth who is attending the public schools, a young daughter, who is also attending school, the father, a bank officer in one of the large banking institutions of Baltimore city, and a daughter, a trained nurse. On December 26 the father consulted me at my office, stating that his son had a high fever and an inflamed throat and asked for medicine. I prescribed for the youth and saw him the next day. My notes, made at the time, read that he had a temperature of 100.4; throat very much inflamed; a thick deposit on both tonsils, and a foul-smelling breath; tongue very much coated; pulse 72; respiration 16. Feeling that I could not make a positive diagnosis in the case without the assistance of laboratory measures, I returned to the house at 2 p. m. and took a swab from this young man's throat. At about 4 p. m. the culture was in the laboratory of the State Board of Health. During these two visits the following conditions developed and confronted me: the matron of the military school must return to her duties the next day at 12 m., the train leaving at that time; the bank official must return to his bank; the two cadets must be in readiness to return to their school at the expiration of their furloughs;

<sup>\*</sup> Read before the Baltimore County Medical Association, January 20, 1910.

the two children must return to the public school when their vacations expired. If the disease from which the young man was suffering was diphtheria, the military school, which contained some 250 students, must be protected, and the matron, particularly, must be prevented from returning; if the disease was not diphtheria, then an injustice would be done to the matron and the other members of this large household by quarantining them. A correct diagnosis must be made before 10 a. m. the next day. My action in the matter was this: the matron and her young son were sent to a home where there were no children, to be in telephone communication with the mother of the sick young man; the cadets and the young children of the family were to remain in the house where they were visiting; the bank official was to use the best precaution he could under existing conditions. At 9.30 a. m., December 28, I learned over the 'phone from the laboratory of the State Board of Health that the culture was negative. I immediately telephoned this report to the mother of the sick patient; she, in turn, telephoned to the matron. With this information it was safe for her to return to her duties at the military school; it was safe for the cadets to return to their duties as students. The subsequent history of the attack showed that the diagnosis was a correct one. The principal reason for reporting this case is to show the great responsibility resting upon the physician having such a case in charge; the many directions in which such a case ramifies, and the commercial value of a correct diagnosis, the disaster which might have resulted had the case been diphtheria and diagnosed tonsillitis, and the different members of this household allowed to return to their several duties, also the short space of time in which this information had to be gathered and acted upon, and the decision made.

## DISEASES DUE TO THE ANIMAL PARASITES IN NORTH CAROLINA.\*

BY DR. WILLIAM ALLAN, '06.

Of the men who every year go into medicine in the South, probably more are educated in Baltimore than any other city in the country. It can hardly be denied that certain tropical diseases have existed in that

<sup>\*</sup> Read before the Baltimore City Medical Society, February 18, 1910.

section for years, unrecognized, and that at present the fewest number of men give these diseases the attention their importance deserves. I recently heard that a real case of hook worm disease had been discovered in a neighboring North Carolina town and that in a town over in South Carolina a bottle of hook worms sent from Porto Rico had created quite a stir; undoubtedly more than 10 per cent of the inhabitants of these two towns are harboring the parasite. This condition of affairs will not seem strange when we recall the fact that the microscope is still rare in the South and that clinical methods do not go very far toward the diagnosis of the diseases caused by the animal parasites. The North Carolina Medical College has had to adopt the plan of making each student buy a microscope, counting this expense as part of his tuition.

Very few men in active practice there will take the time and trouble to renew their acquaintance with the microscope and do laboratory work. So that the importance of these semi-tropical diseases will not be fully appreciated until a newer generation, trained in animal parasitology, comes into the South bringing microscopes with them.

For these reasons I wish to discuss briefly, here in Baltimore, the relative importance of, and a few of the problems of those diseases of the South caused by the animal parasites.

In less than two years' time, in a small general practice, the writer has encountered 72 cases of these various diseases, exclusive of syphilis, Vincent's angina, monads, and parasitic insects. In trying to determine the importance of intestinal parasitism from the standpoint of life insurance examinations, differential blood counts were made in 100 supposedly normal people; about 20 per cent of these showed an eosinophilia above 6 per cent.

The disease which holds first place in the affections of the profession and of the laity alike is malaria. The great majority of our cases of hook worm disease, of amebiasis, of strongyloides, of para-typhoid, of liver abscess, and many cases of incipient tuberculosis, of gall stones, etc., are diagnosed clinically as manifestations of malaria. Quinine is given as regularly as calomel. "Biliousness and a touch of malaria" is probably the most frequent diagnosis made in North Carolina. In 120 examinations of stained and fresh specimens of blood for malaria, the writer has found the organism in only 6 cases. These were all tertian. Though

malaria is a scourge in tide-water, in the Piedmont it seems to be comparatively rare, particularly æstivo-autumnal malaria.

In Charlotte mosquitoes may be caught swarming in the open during every month of the year. They stop biting early in October and by November no longer come into the houses. Attacks of chills and fever are not common during the winter, but as soon as the sun gets warm in April, these attacks appear again, before the hibernating mosquitoes begin to bite. Two of our cases were small children with large spleens, who began to shake in the early spring after quietly carrying the parasite all winter. Most of us raise our own supply of mosquitoes on the premises.

In a cotton country, which is necessarily rather flat and sandy, water supply becomes a difficult problem. Surface wells constitute the chief water supply of the Carolinas. Without running water in the house, modern toilet arrangements are of course impossible; the people have not yet been educated up to the dry pail system, so that soil pollution is practically unlimited. In a warm country, children go barefooted, almost without exception. These three things—well water, soil pollution, and going barefooted—lead to what is probably the greatest single factor in the public health problem in the South—intestinal parasitism.

Of the parasitic worms, the tape-worm of beef and the pin-worm are about as common in Carolina as in Maryland. Round worm infections are much more common there than here, particularly among the negroes, but less common than among your immigrants from Southern Europe.

Strongyloides intestinalis constitutes about 3 per cent of the parasitic worm infections in North Carolina, although in Georgia and the Gulf States the per cent is considerably higher. In one of my cases the hemoglobin was below 10 per cent and the patient too weak to risk large doses of thymol. Another came in with a diagnosis of pellagra, based on chronic eczema, diarrhea, and a bald tongue.

Of course the great parasitic worm of the South is the hook worm. In tide-water and in the hill country from 15 to 25 per cent of the population harbor this parasite. Among the mill people of Charlotte, imported from other sections of the State, the per cent is over 20; among the clerks in the various business concerns of the town, mostly country-bred boys, the per cent is about 15; from 20 to 30 per cent of our medical students are affected.

There are several interesting things about this disease; in the first place a light infection causes no objective symptoms and only a routine differential blood count or a routine examination of the feces will discover the presence of the parasite in a very large number of cases. People who move from the country into town, where they are not constantly exposed to reinfection, and those who put on shoes for good when they are 15 or 16 years old, gradually recover; cases are not common after 30 years of age nor in those who have lived in town for 10 years. As a routine examination of the feces is at present impossible, the value of a routine differential blood count for cosinophiles becomes evident, considering the number of light cases. As about 90 per cent of cases of all grades show cosinophilia, we consider this the most important diagnostic procedure that can be undertaken in the South.

Of all the various diagnoses that are applied to cases of anchylostomiasis that have neither marked anemia nor constipation, the commonest is neurasthenia. Many cases of intestinal parasitism are neurasthenics, and are passed on to our specialists in nervous diseases, as propositions that are too tough for the general practitioner. The removal of parasites often causes some surprising recoveries in these people.

The protozoan intestinal parasites, amebæ and monads, are generally found together; as the significance of the monads has not been definitely settled, we shall pass them over, merely stating that the association of these organisms is so constant that it is hard to believe it accidental.

With the exception of tuberculosis, amebiasis is probably the most prevalent disease in the Piedmont section of North Carolina. Out of 72 cases of animal parasitism, 42 were cases of amebiasis. In 1908 I personally saw more deaths from this disease than the total reported death rate of the town for typhoid fever. Two years ago I was told that dysentery was unknown in Charlotte; two weeks ago I was told dysentery was unknown in High Point.

The first question that arises in this problem is as to the specificity of the intestinal amebæ. Infected water-supplies cause amebiasis; from 25 per cent of the vegetables of Charlotte amebæ can be grown. Does the Entameba histolytica thrive outside the human body in water and soil, at ordinary temperatures, or do these free living amebæ possess the char-

acteristic of facultative parasitism? On the answer to this question depends the prophylaxis of the disease.

In the 50 per cent of cases that have bloody, mucous diarrhea (ulcerated sigmoid or rectum), the diagnosis is easy; in the 20 per cent that have from one to four semi-solid fermented stools daily, alternating with constipation, the examination of a semi-solid stool will show amebæ about half the time; in the 30 per cent that do not have diarrhea, the diagnosis is very often difficult. A saline cathartic will sweep down the organisms, but at the same time it often destroys their motility. After a purge amebæ are generally scarce.

My attempts to destroy amebæ from cultures and in stools with solutions of quinine, ipecac, vegetable acids, such dessicating agents as Rochelle salts and magnesium sulphate, and with coal oil have been very disappointing.

The administration of ipecac, grs. 60 daily, has not been effective in my hands in bringing about a permanent cure. In fact out of 42 cases treated by medical methods, only one individual seems to have recovered permanently. The relief of symptoms by rest, diet, irrigations, cathartics, and ipecac is easy and fairly certain, but only palliative. Amebæ may disappear from the stools for eight months but within two years the symptoms return. Treatment is simpler for the attending physician by appendicostomy or excostomy, but the end results have yet to be determined.

About half of our cases have shown an eosinophilia ranging from 5 to 9 per cent, while that from anchylostomiasis has generally been from 10 to 15 per cent. In spite of the weight of authority to the contrary, we are forced to believe that a moderate eosinophilia is common in amebiasis. In examining blood for malaria, this eosinophilia has repeatedly directed our attention to the intestinal tract.

The bald tongue is supposed to be pathognomonic of pellagra; but in the asthenic stage of dysentery the tongue often presents a similar appearance. This is especially confusing as Capts. Nichols and Sinclair of the Army Medical Corps, in Peoria, and the writer in Charlotte, have shown that in over 75 per cent of pellagrins amebæ are present in the stools.

Whatever the cause of pellagra, whether a toxemia or a parasitic infection, it must be reckoned with by every man who comes to practice medicine in the South.

# INTESTINAL PARASITES AND THE DIAGNOSIS OF NEURASTHENIA.\*

BY WM. ALLAN, A. B., M. D.

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Our standard text-books fail to mention intestinal parasites as the cause of neurasthenia. Neither do they record any of the nervous or mental symptoms that accompany parasitic infection of the intestines.

Ordinarily it would be impossible to confuse the typical cases of uncinariasis or amebiasis with neurasthenia, whatever the nervous or mental symptoms might be, but there are many atypical cases of intestinal parasitism in which the picture is that habitually seen in chronic neurasthenia. For instance, no one would think of a history of ground itch, anemia, eosinophilia, constipation with clay-colored stools, and muscular weakness as meaning anything but uncinariasis; and in the same way chronic dysentery with anemia, with blood and mucus in the stools, and with painful defectation, means amebiasis. But we see cases of uncinariasis in which there is no history of ground itch, with hæmoglobin above 85, and with regular and normal bowel movements; likewise cases of amebiasis without marked anemia, giving a history of perfectly normal bowel movements or slight constipation for a number of years.

These cases are sent to our neurologists as chronic neurasthenics, after going the rounds in their home towns for from one to ten years. They complain of muscular weakness, headache, sleeplessness, depression, irritability, sometimes loss of weight; they tire out mentally very quickly, think and talk about nothing but themselves. They rarely give a voluntary history of indigestion; appetite good or variable. They are all habitual medicine takers and are particularly partial to large doses of calomel and quinine as remedies for "biliousness and a touch of malaria"—that grand old diagnosis that covers anything from gall stones to rheumatism.

Case 1.—A. B. C., white, male, age 30. Native of Florida. Family history negative. For ten years had had biliousness and coated tongue. Says he has been sallow for six years, though to all appearances he is not anemic. For last five years has been below his normal weight. Occasionally constipated, occasionally has diarrhea. Takes his temperature twice daily and says it runs from 96 to 98.5 F. Six months ago had his appendix removed; his surgeon afterwards told him it was perfectly normal. Appetite variable, sleeps fairly

<sup>\*</sup> Reprint from The Southern Medical Journal, October, 1909, pp. 1037, 1038.

well; easily fatigued mentally and physically; depressed; irritable. Thinks and talks a great deal about his health. Says he has taken medicine pretty steadily for ten years. Had ground itch when a boy.

May 14 case was referred to me for blood examination for malaria. Hæmoglobin 90. No malarial organisms. Eosinophiles 10 per cent. Urine negative. Physical examination showed only exaggerated reflexes and some loss of weight. Feces showed a very few eggs of Necator Americanus.

May 16. Patient threw away his thermometer and took thymol, grs. 30. Less than a dozen worms were seen.

May 19. Feces still showed eggs. Thymol, grs. 30. A few worms recovered.

July 20. Feces showed no eggs. Thymol, grs. 60. No worms recovered. Patient has gained seven pounds; still has coated tongue, but says he feels stronger and better than he has in years.

Case 2.—Mrs. C., white, female, age 34. Wife of Presbyterian divine. Native of eastern North Carolina. On July 5 case was brought to me for a blood examination for the sake of the mental effect the procedure would have. Blood showed hæmoglobin 65, eosinophiles 10 per cent. Inasmuch as the patient looked anemic and gave a history of chronic constipation for which she took purgatives regularly, hook worm was suspected and a constipated stool was requested. In looking over a semi-solid stool next day for eggs, amebæ and monads were seen. Patient was ordered to the hospital and put on routine dysentery treatment. After the initial dose of salts amebæ and monads were plentiful in the stools.

She gave a history of malaria over twelve years ago followed by dysentery lasting six weeks. Married eleven years; four children and one miscarriage. Youngest child thirty-four months old. Slight perineal laceration at the birth of first child. Menses were irregular a year ago, but have been regular for the last eight months. Backache, headache and depression precede the menstrual flow. After birth of third child five years ago was weak for a long time and has been very nervous and anemic ever since. Appetite good; sleeps well; tires easily; complains of constipation and sick headache. Has never been strong during the last twelve years.

Physical examination negative; urine negative.

CASE 3.—J. D. S., white, male, age 20. Native of Anderson County, S. C. (In the sand belt.) Farmer. Seen in consultation with Dr. S. M. Crowell, July 22. Case had been sent to him as a chronic neurasthenic with a tentative diagnosis of beginning of locomotor ataxia.

Family history showed a variety of nervous afflictions in the past three generations.

Past history: Ground itch off and on for the last ten years. For past six years has been treated for nervous indigestion. Had measles four months ago, followed by hoarseness and three weeks' diarrhea. His indigestion and nervousness have become very much worse. Feels cold and numb. Thinks he is turning dark. Says feet feel like a fish. Has enormous appetite. When he goes to bed at night feels as though something was closing down on him. Says at night his eyes stare and jerk from side to side, etc. Talks in a loud voice, gets very confidential, cries at times and is often depressed. Enjoys rehearsing his symptoms. Smokes cigarettes almost continuously.

Physical examination negative except that skin looks a muddy yellow. Blood: Hæmoglobin 70, eosinophiles 6 per cent. Urine normal. Feces: Light yellow, pasty. Full of eggs of Necator Americanus.

July 23. Thymol, grs. 60, administered and 151 worms recovered.

Conclusions.—Intestinal parasitism is a frequent cause of chronic neurasthenia and at times the pronounced nervous and mental symptoms entirely overshadow the vague symptoms of intestinal invasion. In view of the wide prevalence of intestinal parasites in the South, a hæmoglobin estimation, a differential count for eosinophiles, and a microscopical examination of the feces are essential before a diagnosis of primary chronic neurasthenia is justified in this latitude.

# INCISED WOUNDS OF THE LIVER DUE TO ACCIDENTAL TRAUMATISM. REPORT OF A CASE COMPLICATED BY EVISCERATION.

BY DR. ALEXIUS McGLANNAN, BALTIMORE, MD.

Hemorrhage is the principal source of danger in wounds of the liver. The bleeding from the organ itself is always profuse and may be complicated by injury to the portal vein, or to the other vessels of the region. For this reason the literature of liver surgery contains many reports of methods for the control of bleeding from the organ. Infection is a rare cause of death unless the liver wound is complicated by perforation of the intestine. In 399 cases studied by Thoele, there were eleven deaths from peritonitis. All of these fatal cases had accompanying perforation of the intestine.

Traumatic lesions of the liver are most often subcutaneous ruptures. Gunshot or stab wounds are next in frequency, while incised wounds are uncommon. With intact abdominal walls, or only a small parietal wound, the diagnosis of the seat of the injury is very difficult. Usually in these cases one must operate on finding the general symptoms of intraabdominal hemorrhage, and depend on the conditions found at the laparotomy to indicate the seat of the trouble.

<sup>&</sup>lt;sup>1</sup>Read before the Medical and Chirurgical Faculty of Maryland, Baltimore, Md., 1909.

<sup>&</sup>lt;sup>2</sup> Verh. d. D. Ges. f. Chir., 1905.

The diagnosis of injury of the liver has been studied by Hubbard, and Dencks. Hubbard states that it is a mistake to waste time in an attempt to distinguish definitely between rupture of the liver and that of other organs, because the treatment of each requires laparotomy. He gives as the signs of rupture of the liver: shock with rigidity and muscle spasm, and tenderness over the liver area, associated with movable dulness in the flanks. Jaundice is a rare symptom, and can only occur late, from absorption of bile through the peritoneum.

Tilton adds to local pain and tenderness the following special signs: Radiation of pain to the right shoulder, lagging respiratory movement on the right side, dulness in the right iliac fossa from accumulation of blood there, and a gradually increasing pain as the blood is diffused throughout the abdomen.

Injuries to the liver are infrequent. The size and position of the organ, as well as its consistency, make it especially liable to rupture in severe contusions of the abdomen. Tilton (loc. cit.) shows that the liver is injured more often than all the other solid abdominal viscera combined. Thoele (loc. cit.), in 1905, collected 399 laparotomies for hemorrhage from the liver. Each year since then several cases have been reported, and the June volume of *Progressive Medicine* has references to liver injuries in Foote's review of abdominal surgery. In the April number of *International Clinics* for 1908 and 1909, Bloodgood discusses these injuries and their treatment.

The most common seat of injury is the right lobe. Kehr makes it six to one as compared with the left lobe, and states that the convex surface is injured about twice as often as the concave. Hubbard makes the ratio three to one in rupture. Of course any part of the liver may be involved in a gunshot or stab wound.

The mortality from injuries to the liver is high. Thoele puts it at 40 per cent for all cases after immediate operation, compared with 67 per cent in the cases treated expectantly. The prognosis depends on the extent of the liver injury, the number of complicating injuries to other

<sup>&</sup>lt;sup>3</sup> Boston Med. and Surg. Journal, 1906.

<sup>&</sup>lt;sup>4</sup> Deutsch. Zeitsch, 1906, LXXXII, p. 307.

<sup>&</sup>lt;sup>5</sup> Annals of Surgery, Jan., 1905.

<sup>6</sup> von Bergmann's Surgery, Vol. IV, p. 632.

viscera, and most of all on the length of time between the receipt of the injury and the operation. The best results are obtained when the operation is performed within six hours after an uncomplicated injury. Rupture of the intestines greatly augments the seriousness of the condition by increasing the probability of peritonitis. Hemorrhage was the cause of death in about half of the fatal cases.

The important point in the treatment of liver injuries is the control of hemorrhage. Many methods have been devised, some of them very ingenious. We owe most of them to the study of means for removing liver tumors. A very good history of the development of liver hemostasis is given by Schroeder, and by Cullen. It is interesting to note among the pioneers in this work, Dr. Tiffany, of this city, who removed a small growth from the liver, using the cautery to prevent hemorrhage. This method enjoyed great popularity among the earlier workers, but the advantages of the other methods are so great that its use has been abandoned for the most part.

In general we may divide the methods into tamponing, suture over some interposed material, and direct suture. The tamponing is usually by gauze packing, and in many methods is associated with cauterization. The advantage of the gauze pack is that it provides drainage. Its disadvantages are the necessary open wound, and the pain and possibility of new hemorrhage when it is withdrawn. As the uncomplicated wounds do not require drainage, the tampon has no advantage in this class of cases.

Suture over some interposed material has brought out the most ingenious contrivances. The object of this method is to prevent the sutures cutting out of the liver, or strangulating too much tissue in their grasp. Ceccherelli and Bianchi used perforated whalebone and decalcified bone plates; Payr and Martina, perforated magnesium bands through which the sutures were passed and tied. Both of these methods are described in Schroeder's article, as well as his own experiment of using boiled beef tendon instead of the plates, etc.

Knott 10 describes a new method for this group of cases. It consists in

<sup>&</sup>lt;sup>7</sup> Surg., Gyn. and Obst., Vol. II, p. 52.

<sup>&</sup>lt;sup>s</sup> Jour. Amer. Med. Assoc., April 22, 1905.

<sup>9</sup> Md. Med. Jour., 1890.

<sup>&</sup>lt;sup>10</sup> Annals of Surgery, 1906, Vol. 46.

passing a strand of heavy catgut deep in the liver substance on both sides of the wound, about half an inch from its edge. The catgut should enter and leave the liver tissue about an inch beyond the ends of the wound. These strands are fixed by tying their ends around a roll of catgut. The transverse sutures are put in so that they pass around these longitudinal strands.

Carl Beck " describes a method of transplanting a flap of peritoneum, muscle and fascia from the abdominal wall and using this strip to support the sutures.

The direct suture is the simplest method. This may be a continuous chain, as was the original suture of Auvray, or a continuous mattress, as used by Kousnietzoff. To this latter surgeon we owe the blunt needle that Mikulicz says, "represents the egg of Columbus in the technic of liver surgery." Cullen (loc. cit.) reports a case of resection for tumor in which he used simple mattress sutures overlapping one another. Thoele strongly advises a firm intra-hepatic lacing by mass ligature, tight enough to cut through down to the vessels.

We believe that it is better to tie the sutures with just enough force to avoid cutting through, using individual ligatures for any large vessels exposed. Such a ligation gives definite hemostasis, while it avoids complete anemia of the parenchyma.

Pringle <sup>13</sup> recommends temporary compression of the portal vein and hepatic artery in order to stop the bleeding from the liver while sutures are being inserted. He records his clinical experiences with rupture of the liver and gives the result of his experimental investigation with the effects of this compression. Pringle found that compression for an hour allowed him to resect the liver, bloodlessly, and had no lasting effect on the circulation of the intestines. The bowel became cyanotic during the operation, but regained its normal color as soon as the clamps were released from the portal vein.

Pringle also mentions two maneuvers for exposing the cut surface of the liver. One consists in dividing the coronary and right lateral ligaments so that the liver may be dislocated and delivered into the abdominal

<sup>&</sup>lt;sup>11</sup> Jour. Amer. Med. Assoc., 1902.

<sup>12</sup> Centrallblat f. Chir., 1905.

<sup>&</sup>lt;sup>13</sup> Annals of Surgery, October, 1908.

wound. The other method is to divide the ribs and retract an osteoplastic flap of the thoracic wall. This latter method seems the easier to carry out, and a modification of it was employed in my case.

The process of repair and the after effects of liver wounds have been exhaustively studied by Ponfich, whose reports published in Virchow's Archives in 1889, 1890 and 1895 are the basis for most of our knowledge of the subject. Most interesting is the regenerative power and the compensatory hypertrophy of the liver after removal of extensive areas of the organ.

Deep central ruptures may result in abscesses or cysts. Thomas "reports a case in which a tumor slowly developed after an abdominal contusion. The physical signs led to a tentative diagnosis of pseudo-traumatic pancreatic cyst. At operation the tumor was found to be a blood and bile cyst in the lesser omental cavity connected with an injured lobus Spigelii.

Among other effects of severe injury is the sequestration of a portion of the liver substance. Such an area may be separated and be found free in the peritoneal cavity.

The case that I shall report is of interest because of the extensive wound of the abdominal wall; the evisceration with extrusion of the stomach and bowel during four hours; and the automatic hemostasis as a result of this evisceration. In the treatment of the patient the important points are the methods of dealing with the exposed viscera, the suture of the liver, and the acute dilatation of the stomach occurring as a sequel.

### S. 2171. INCISED WOUND OF LIVER, EVISCERATION. SUTURE.

The patient, a white male, age forty-five, was admitted to the City Hospital, October 2, 1908, suffering from a saw wound of the abdomen. The accident took place at 8 a.m. The patient's shirt was caught in a buzz-saw at which he worked, and he was drawn onto the saw, the left side of the abdomen first coming in contact with the blade.

The first aid was given by a local physician, who, apparently not recognizing the extent of the injury, had the man taken home. I saw the patient about an hour later, after an unsuccessful attempt had been made to etherize him. The man was quite shocked, complained of pain in the epigastrium, and of nausea. He was bleeding from the margins of the abdominal wound. The anterior wall of the stomach and a loop of colon protruded through the wound; the stomach was dilated. After almost two hours' delay, permission was finally obtained from the family to remove the man to the hospital.

<sup>&</sup>lt;sup>14</sup> British Med. Jour., January 4, 1908.

On admission the patient was taken at once to the operating room and prepared for operation. His condition was that of severe shock, and 500 cc. of salt solution were given at once, subcutaneously. The temporary dressing was removed and the protruding stomach covered with sterile towels wet with hot salt solution. The skin of the abdomen and chest were then scrubbed and disinfected, the peritoneum being protected by salt towels packed around the opening. During this time the patient was carefully etherized and when the preparations for operation were complete the wound was thoroughly inspected.

EXAMINATION.—With the patient under ether, the signs of shock were less pronounced. The wound extended from one inch outside of the mammary line on the left side to the nipple line on the right side. It was about seven inches long, running obliquely across from the tenth and eleventh to the ninth rib. Through this wound the stomach was protruded, greatly distended, and at the lower left portion a loop of colon was caught outside. The wound edges tightly grasped the protruded viscera.

OPERATION.-12 m., October 2, 1909. McGlannan. The wound edges were retracted and the protruded stomach and colon reduced. The divided epigastric vessels were clamped and later tied. With the stomach in the abdomen the liver came into view and was found bleeding freely from an incised wound of the upper surface of the right lobe near the falciform ligament. wound was about seven inches long, shallow at each edge and gradually deepening to about one inch at the center. There was practically no blood in the peritoneum, so that the hemorrhage from the wound must have been controlled by the pressure of the dilated stomach against the diaphragm. A large gauze pack was put in the liver wound, while the opening in the abdominal wall was enlarged in order to pass the sutures. To do this it was necessary to divide the eighth and ninth ribs, bringing the abdominal wound close to the insertion of the diaphragm. With this exposure, it was not difficult to place the interrupted mattress sutures. These overlapping catgut sutures were put in with an ordinary needle and were tied just tight enough to control the bleeding. They showed no tendency to cut out.

The peritoneum was sponged with salt gauze to remove the blood and then the abdominal wall was closed with catgut in layers. The peritoneum was sutured with a continuous suture; the muscle and fascia with interrupted stitches. The skin was closed with interrupted silk. Protective drains were carried down to the peritoneum at each angle of the wound and about two inches from the center on both sides. The muscle was quite ragged and the skin edge severely contused.

AFTER TREATMENT.—Continuous salt solution by the rectum was given with the patient in the upright position. He rallied from the shock promptly and was quite comfortable at the end of twelve hours. On the second day he developed an acute dilatation of the stomach with all the classical symptoms. Immediate lavage relieved the condition and from that time on there were no serious complications.

The muscle and skin wound broke down at the left side and near the middle. This wound suppurated quite a little and two small sinuses persisted for eighteen weeks until a knot of catgut was discharged. The patient returned to work at the end of twelve weeks, and now, thirty-two weeks since the accident, is well and working every day. The wound is tightly healed and there is no hernia.

#### SATURNISM BY COSMETICS.

#### By DR. M. CHIDECKEL, '08.

That there may develop a chronic lead intoxication by slow absorption through the skin has been definitely settled by numerous clinical examples. How far saturnine toxemia effects the motor nerves, and whether it really produces a general arterio-sclerosis are problems as yet unsolved.

We know from our pathological studies that plumbism produces a parenchymatous neuritis of the peripheral nerves. The spinal cord, strange as it may seem, enjoys immunity. All the other centers undergo definite degenerative changes. Morbid changes take place in the brain, leading to the so-called "lead encephalopathy," causing neuro-retinitis, aphasia, amaurosis, hysteria, delusional insanity and acute mania.

There is, however, one form of lead poisoning which is generally overlooked, and certainly deserves more attention than it is given by the general practitioner, and that is saturnism by cosmetics.

The two cases herein reported were treated for various ailments. The treatment given them was largely symptomatic. The causative agent has never been sought, and, therefore, never found, with the result that one at least is in all probability doomed to suffer all her life from the morbid changes that have taken place in her brain due to slow absorption of lead poison.

CASE 1.—Patient is a young female, of healthy appearance. Given age is 23. Family history absolutely negative. Until three years ago she did not have a sick day. Bowels were always regular. She menstruated every 28th day without any unpleasantness.

About three and a half years ago patient began to use a patent medicine on her face for the purpose of removing freckles and for beautifying her complexion. Six months later she began to suffer from violent, throbbing headache, vertigo, loss of memory and dimness of vision. Two months later the patient was beginning to have delusions of persecution, was melancholic most of the time, cried a great deal, and was hilarious, laughing without any cause, several times during the day. A few weeks later her condition became so aggravated that she had to be removed to a sanitarium where she spent eighteen months and was discharged cured. She did not use the paint for freckles on her face for five months afterwards and was well. She finally began using it again. Six months after that the violent headache returned. As the headache was unilateral and came on periodically, she was treated for migraine. A few weeks later dysmenorrhea made its appearance, and patient was almost prostrated with pain.

She came to my office asking to be relieved of her suffering. She complained of vertigo, pain in the eyes, tinnitus, severe cramps in the abdomen,

obstinate constipation and general nervousness. Her face was pale. Reflexes were slightly exaggerated. The abdominal muscles were rigid and contracted, the navel being the seat of pain of the greatest intensity. Lungs were negative. Chest showed a functional murmur, systolic in time at the mitral area, which was not transmitted. There was the typical wrist drop, though no blue line could be detected, the patient having taken good care of her teeth. A few days later the patient became worse. In the meantime I had her eyes examined by a famous ophthalmologist of this city who could find nothing in her eyes to justify her condition, though I suspected some strabismus. All this time she has not stopped a single day from using the paint on her face. Chemical analysis has proved this to contain 5 per cent of mercury, the balance being made of bichromate of lead and probably vaseline or lanolin. The condition of the patient became so serious that she had to be removed again to same sanitarium for mental sufferers. I have since learned that she is getting violent and that her condition is almost hopeless.

CASE 2.—Patient is 21 years of age. Is a very nervous individual, face pale and lips somewhat cyanotic. Family history: Father died of cancer of the stomach, one uncle died of tubercular laryngitis, and mother is having diabetes. Personal history: Had all the infantile diseases and several years ago she had typhoid fever twice. Complaint: Great irritability, cramps in the muscles of the calf, alternate constipation with diarrhea, cramps in the abdomen, pain in the epigastrium, weakness, severe headache, vertigo and anorexia.

Physical examination: Lungs negative. Heart: Cardiac dullness both superficial and deep normal. Tachycardia present. No murmur audible. Abdomen tender to pressure and marked rigidity in both recti. Reflexes normal. Pupils normal. A test breakfast was given and stomach contents showed nothing abnormal. Specific gravity of urine was 1005. Sugar and albumin negative. Tongue coated and blue line on the gums distinctly marked. Wrist drop present.

On being questioned patient admitted that she is using a powder on her face several times a day. The powder is being rubbed on her cheeks rather vigorously. Chemical analysis showed this powder to contain about one-third of lead carbonate, the rest being made up of prepared chalk and other substances of no interest. Nothing was prescribed for the patient at the dispensary where she came under my observation, but she was ordered to stop using the powder on her face. The order was obeyed. Patient was told to come every other day so that she could be watched. At the present writing, six weeks after she stopped using this powder, she has almost entirely recovered.

Was it anything else but a case of poisoning by lead? May not the head-ache, hysteria, and many other nervous affections, so common among women, be due to saturnisms, with the use of cosmetics as the causative agent?

WILLIAM S. GARDNER, M. D., EDITOR, 6 W. Preston Street.

JOHN RUHRÄH, M. D., ASSOCIATE EDITOR, 839 N. Eutaw Street.

CHAS. EMIL BRACK, M. D., Business Manager,

## THE JOURNAL

### OF THE ALUMNI ASSOCIATION

OF THE

# COLLEGE OF PHYSICIANS AND SURGEONS, BALTIMORE.

### TRANSMISSION OF BOVINE TUBERCULOSIS TO MAN.

This subject has been discussed so much and by so many observers one almost hesitates to say anything more about it. It is a matter of such importance, however, that one cannot pass over the subject without noting the article by Shaw, Journal of the American Medical Association, November 27, 1909, which gives a statement of the opinions of various authorities and some interesting discussion of the subject.

The question cannot be regarded as definitely settled, but it may safely be stated that there exist two types of tubercle bacilli, one human and the other bovine. These can be told by cultural methods which can be carried out in any well-equipped laboratory, and apparently the bovine bacilli retain their characteristics even though transplanted into man and remaining there for years. It is also safe to assert that almost all of the cases of human tuberculosis are infected directly from other human cases, and that the means taken to reduce the mortality from this disease should undoubtedly be directed mainly towards reducing such infection.

Such observers as Park place the number of infections from the bovine type at about 1.5 per cent of all the fatal cases, this calculation being made for New York City and would represent about 200 deaths a year from this source, a comparatively small proportion of the total number of deaths from tuberculosis.

The only way to determine the exact truth about the matter is continued systematic study of the subject, not only in one spot but throughout the entire world. There has been so much popular talk about the transmission of tuberculosis from cattle that there is danger of diverting the attention due to human tuberculosis, fresh air and sanitation of the milk supply, and whilst every one recognizes that the milk supply in America is very much in need of betterment, it is hardly proper that this should be directed mainly from the standpoint of tuberculosis. There are plenty of other good and sufficient reasons why the general milk supply should be improved, and not only tuberculosis but the danger of other diseases eliminated as far as possible.

Most of the cases of bovine tuberculosis occur in children, infection being through the intestine and the tuberculosis usually starting as a glandular type.

Holt states that "infection through the intestinal canal by means of tuberculous milk I believe to be a very infrequent means of acquiring tuberculosis in infancy."

# THE ALUMNI ASSOCIATION MEETING AND COMMENCEMENT.

The annual meeting of the Alumni Association will be held in the college building Wednesday, June 1, at 8.30 p. m. Dr. E. A. Bowerman, '95, of Buffalo, N. Y., will deliver the annual address. The Alumni meeting will be followed by a smoker, having for its chief attraction the reunion of the class of 1895.

The Commencement exercises will be held at 8 p. m. Thursday evening, at which time Dr. W. T. Councilman, Professor of Pathology at Harvard University, will deliver the address. This will be followed by the annual dinner which will be held at the Hotel Rennert at 9.30 p. m.

### THE REUNION OF THE CLASS OF 1895.

At the suggestion of the members of the class of 1895, a circular letter was mailed to all the members of the class, and a sufficient number have signified their intention of being present at the 15th anniversary on June

1 and 2. Dr. E. A. Bowerman, the honor man of the class, now of Buffalo, N. Y., will deliver the annual address at the Alumni Association meeting, as noted above, and this will be followed by a smoker.

There will be some form of entertainment of the class for Thursday afternoon depending upon the weather conditions. The Commencement will be on Thursday evening, June 2, at 8 p. m. at Albaugh's Theater, and will be followed by a dinner at the Hotel Rennert.

The headquarters for the class will be at the Hotel Junker, 20-22 E. Fayette St. This hotel is for gentlemen only, and those members of the class who will be accompanied by their wives can obtain accommodations at the Rennert.

Arrangements have been made by Drs. McGlannan and Brack, and it is hoped that all, who can possibly get away, will join in this attempt to make this class reunion one of the best that has yet been held.

### THE TRIMBLE MEMORIAL FUND.

It will be a great pleasure to all the numerous friends of the late Dr. Trimble to know that the committee which had in hand the collection of money for a memorial fund has been very successful, and at the last meeting of the Medical and Chirurgical Faculty turned over to that body \$5112.51. This property is to be invested in securities and the net income is to be paid out once in every three years, beginning with the year 1913, to defray the cost of securing the services of an eminent contributor to the science or art of medicine or surgery for the delivery of one or more lectures at the annual meeting of the Medical and Chirurgical Faculty of the State of Maryland, or at such other time as the council of the said Faculty may determine. The terms of the gift also provide that if the fund shall be so increased that the triennial interest amounts to \$1000, the excess of this shall be set aside to procure a suitable bronze medallion of Dr. Trimble, and that thereafter each lecturer shall be presented with a small bronze copy of this medallion with a suitable inscription on the reverse side in honor of the Isaac Ridgway Trimble lectureship. This lectureship should add great interest to the meetings of the Faculty and will be a most lasting and suitable memorial for one of the most prominent and useful members that the Faculty has ever had.

CLAIMS ARISING FROM RESULTS OF PERSONAL INJURIES.—By W. Edward Magruder, M. D., Associate Professor of Clinical Medicine, College of Physicians and Surgeons; Visiting Physician Mercy Hospital and Bay View Asylum. Medical Examiner and Adjuster for Life, Accident, Health and Liability Insurance Companies, Baltimore, Md. Cloth, pp. 266, price, \$2.50. New York, The Spectator Company, 1910.

This is a little book of 266 pages and deals with the relation of accidents and injuries and claims resulting therefrom. For so small a book it contains a remarkable amount of information and is rather complete in bibliographic references, so that further information could easily be had by any one interested in any particular subject. The author has taken up about fifty of the more important diseased conditions and has pointed out how they may be influenced by accidents. This is the first book that we know of in the English language to be published on this subject, and the author has done his work in a very thorough and satisfactory manner. The book includes a chapter upon X-ray methods of diagnosis and X-ray burns, and a few pages upon post-mortem examinations in those dying from diseases following injury. In the chapter on traumatic neuroses the author quotes Harrison as saying "Of the persons who have demonstrable injuries almost none develop the traumatic neuroses. Among those who suffer from functional nervous disorders after accidents, the majority are not visibly injured, have claims for damages, and of these over 90 per cent recover perfectly after their claims are adjusted." This recalls to mind Dr. Preston's definition given in court of a traumatic neurosis. When replying on cross-examination he stated that a traumatic neurosis was a disease that began with an injury and wound up in a damage suit. Taken as a whole the book would prove a most valuable addition to the library of any one who has to do with insurance and adjusting, and we would recommend it most highly as it covers the ground particularly well. Dr. Magruder is to be congratulated upon the production of a very practical and valuable hand-book.

### Obituary.

Dr. Robert L. Thompson, '91, died at his home in Traphill, N. C., February 20, from pneumonia, aged 50.

Dr. Weldon Alfred Dickson, '86, died at his home in Salamanca, N. Y., February 3, from rheumatic endocarditis, aged 52.

Dr. Nicholas G. Thomas, '68, Washington University, Baltimore, died at his home in Apison, Tenn., November 8, aged 63.

Dr. Dennis Calhoun Atkinson, '80, died suddenly at his home in McDade, Texas, January 19, from cerebral hemorrhage, aged 58.

Dr. WILLIAM PENN DICKS, '75, Washington University, Baltimore, died at his home in Walkertown, N. C., February 18, from neurasthenia, aged 71.

Dr. Isaac J. Daniel, '85, formerly of Battle Creek, Neb., died at his home in Lamont, Okla., December 8, 1909, from general carcinoma, for which repeated operations had been made, aged 57.

Dr. Benjamin Robert Bryant, '81, for two terms a representative in the House of Delegates from Southampton County, Va., died at his home in Boykins, November 14, from pernicious anemia, aged 51.

Dr. Adolphus Theodore Cotten, '79, a member of the Medical Society of the State of North Carolina, and the Raleigh Academy of Medicine, died in that city, November 10, 1909, from intestinal obstruction, following an operation for cholelithiasis, aged 53.

### Personal Motes.

Dr. J. C. Fiske has been appointed superintendent of the S. R. Smith Infirmary in New York City.

Dr. French S. Carey has opened a Pasteur Institute for the preventive treatment of rabies in El Paso, Texas.

Dr. William A. Dorsey, of Seattle, Washington, was married to Miss Blanche Pentz, at Seattle, November 12.

Dr. Charles B. Smith has been re-elected mayor of Washington Burrough, having been elected for the fourth time.

It gives us great pleasure to congratulate Dr. Charles H. Halliday, of Fort Fremont, S. C., on the birth of a daughter on March 24, 1910.

Dr. J. E. Rader has been elected president of the Cabell County Medical Society of West Virginia. The Cabell County Medical Society is one of the strongest and most progressive in the State of West Virginia.

Dr. Charles W. Vogel, of the United States Public Health and Marine Hospital Service, has been transferred from the station at Stapleton, N. Y., to the Quarantine Station at Reedy Island on the Delaware Bay.

Dr. John Doyle, '02, who for a number of years has been practicing very successfully in Grafton, West Virginia, has given up his work there and will spend a year in studying diseases of the nose and throat. He is at present spending three months at the Mercy Hospital and expects to go abroad the remainder of the year. On his return he will devote himself entirely to special work.

### Correspondence.

DERBY, CONN., November 2, 1909.

My Dear Brack.—Enclosed please find \$3.00 subscription for past and present. Everything is lovely up here. Enclosed find a couple of pictures of our bungalow, I am the president and we have lots of sport. It is situated on the banks of the Housatonic River five miles from here. In the picture you will notice a kid; this is not mine but one borrowed for the occasion.

Kind regards to yourself and family, also all the boys.

Sincerely yours,

Col. C. Jacobus Halper, Of several late unpleasantnesses. SCRANTON, PA., November 3, 1909.

DR. CHAS. EMIL BRACK.

My Dear Brack.—Just got your announcement in the Journal this evening that we of '95 were to get together next year.

It is certainly time that this event were pulled off; otherwise we shall all be toothless, hairless old skates not worth coming to Baltimore to see and I doubt not that many of us are already so changed that we would scarcely know each other. Remember me to the boys about the old place who still remember me.

Shall be delighted to attend the reunion next year if I have to walk both ways, so put me down for place at the table.

As ever,

FRANK G. BRYANT.

JARED, W. VA., November 8, 1909.

Dear Doctor Brack.—I see inquiries about Drs. John L. Dunlap, Wm. Shields and Rufus H. Smith. All were from my county, Monroe, W. Va., and graduated in class of '77.

Sorry to have to say the two former are no more. Dr. John L. Dunlap located at his native town, Union, W. Va., practiced medicine and pharmacy for many years and died 10 or 12 years ago. Dr. Wm. Shields likewise located near Union, and practiced until near his death, which occurred several years ago.

Dr. Rufus H. Smith went West, settled at Craig, Mo., became wealthy and quit medicine. I am not positive as to his present address.

Yours fraternally,

C. W. Spangler, '83.

Uxbridge, Mass., January 28, 1910.

Dr. Chas. Emil Brack.

My Dear Doctor.—The back numbers of the Journal at hand, and let me thank you now for your kindness in sending them so promptly. Enclosed please find check for \$5.00, which will cover all from 1905, as you said they had been regularly mailed to my address at Franklin. I took my State board examinations in July, 1905, at Boston and successfully passed the same, and came here in October, same year, and have a good practice.

There are four other physicians here at present and all doing a fair business. We are about half-way between Providence, R. I., and Worcester, Mass.

Remember me to Dr. Sanger and all. With best wishes to P. & S. and yourself.

Yours fraternally,

J. W. LEDBURY.

SHWEIR, Mt. LEBANON, SYRIA, December 6, 1909.

DR. CHAS. EMIL BRACK.

Dear Sir.—Enclosed you will find an order for four dollars for my subscription to the JOURNAL of our beloved Alumni.

I get the Journal regularly and am interested in all its contents.

With best regards, I remain,

Sincerely yours,

M. N. HADDAD, '97.

FREEHOLD, N. J., December 20, 1909.

DR. CHAS. EMIL BRACK, Baltimore, Md.

My Dear Doctor Brack.—At some time or another we are all obliged to report to our dear old Alma Mater the whereabouts of ourselves or our colleagues and at this time it is my sad duty to the college and you, as Editor of the Alumni Journal, to report the sad death of one of the graduates of the class of '05, Dr. Jesse Stilwell, of Freehold, N. J., his death being caused by tuberculosis and diabetes.

Hoping that you will find space in the Journal for the sad news stated above, and that I shall receive my Journal all "O. K.," I am, wishing heartily for the future success of the "College Notes," and wishing you a very Merry Xmas and a Happy New Year,

Very sincerely yours,

Dr. Geo. L. Mack, '07.



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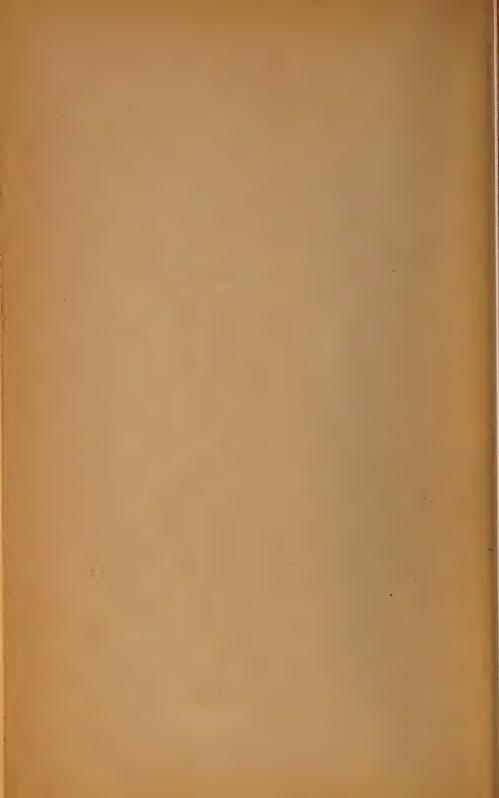
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Vol. XIII

No. 2

JULY, 1910

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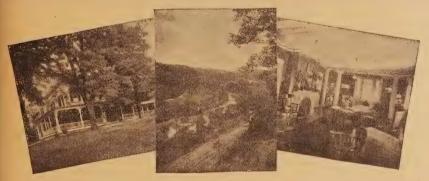
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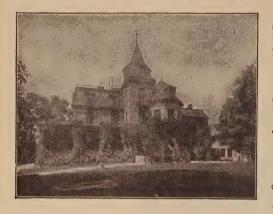
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### THE JOURNAL

### OF THE ALUMNI ASSOCIATION

OF THE

### COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE.

#### THE ADDRESS AT THE COMMENCEMENT.

By DR. W. T. COUNCILMAN,
Professor of Pathology, Harvard University.

In speaking to you to-night I may perhaps be pardoned if instead of choosing some subject of which I may fancy that I have a certain knowledge derived from objective study, I endeavor to give you some of the general conclusions which one sooner or later obtains of a large subject, and the subject which I have chosen is disease. In the daily work of the autopsy room and laboratory as one studies disease under all the varying conditions in which it presents itself in the individual, and in the different organs, certain conceptions of the process in its general relations obtrude themselves upon one, and these I propose to inflict upon you. Such an address as this is a fitting opportunity; I am sure of an attentive audience, for the medical student by long practice has acquired the art of keeping awake under the most trying circumstances, and the dignity of the occasion is sufficient to prevent the audience from expressing any violent disagreement with the speaker. There is also a pleasurable absence of a sense of responsibility in speaking to you. I am in no way responsible for you, not employed to teach you wisdom, and if any of my remarks are at variance with the truth, and therefore harmful, not on my head but on the heads of those who invited me should fall the blame.

Disease has always played an important part in the history of the human race. In every system of religion which man has found time and inclination to formulate, the power to combat disease, to heal the sick, has been a test of its efficiency. Disease has also played the chief role in evolution for it has been through the agency of disease that species not adapted by structure to cope with their environment have been removed to make place for those better fitted. Disease forms also one of the principal subjects of conversation for the human race. Indeed when we inquire concerning the health of our fellows the inquiry is prompted less from the desire to extend help and sympathy if the answer be favorable than to start a conversation on an agreeable personal topic. Rivalry may result but it will rarely be carried to the point of enmity. In the far past disease has generally been thought of as coming to us from bevond the domain of which we have knowledge by sense impressions, and as due to conditions outside of the knowledge and control of man. The investigations of the last half century have torn away the veil of mystery which enveloped the subject, we study it by the methods which have given us knowledge in every department of science, and as our knowledge increases the greater becomes our control of the conditions which give rise to disease. Nor is this knowledge confined to the medical profession. The main facts of disease are becoming common knowledge and the interest of the people in the subject is aroused as never before; the daily newspapers find it to their interest to gratify their patrons by giving out information concerning it, a small part of which is often true. The magazines contain articles on various diseases which, as a rule, are admirable, and are an important means for the education of the people, the modern novelist has also become conscious that there must be some control over the imagination when he depicts the diseases of the characters he uses.

It always makes the comprehension of a subject easier if we can start off with a definition. There is great difficulty in giving a definition of a complex subject, which will fit into all its complexities, but I have thought it is possible to define disease as follows: "Disease is a change produced in living matter, in consequence of which the living matter is no longer in harmony with its environment." In the first place it is evident that this conception of disease is inseparable from the idea of life. If I break or displace a part of a machine, or break the leg of a table, I impair the form or the use of the machine or table but I do not produce a disease. A dead body can have no disease; there may have been a preceding disease and in consequence of the injury done that form of activity which we call life may have ceased, but the changes which are taking place

in the dead body are not disease; they are the changes which take place in any similarly constituted matter under the same conditions and are perfeetly harmonious. If I break the limb of a growing tree I produce an injury and there follows a change in the cell growth at the place injured, resulting in the production of a tissue which differs from the normal or usual type of tissue of that particular species of tree. Had the tree been dead when I broke the limb nothing would have happened except possibly some accelleration of the process of decay at the broken place. It might seem possible to regard disease as simply the negation of the normal, but there is no individual type for the normal. We can form an ideal normal type for a species by taking the average of the measurements of a large number of individuals, but any single individual will in some way depart from that type. Any conception of disease applies to the individual, for individuals are diseased and not species. While it is in general true that there is sufficient variation in the habits and in the structure and function of the individuals of a species, to prevent any common cause from acting in the same way or to an equal degree it is still conceivable that an entire species may become diseased.

Disease then is inseparably bound up with our conception of life. Living matter is matter only and is subject to the laws which govern matter, and like ordinary matter it is composed of atoms and molecules. There is no force inherent in living matter, no vital force independent of and differing from the cosmic forces; the energy which it receives counterbalances the energy which it constantly gives off. The sole condition which distinguishes it from other forms of matter is the constant change which it undergoes and the interchange with its environment. The kind and arrangement of the molecules which compose it are constantly undergoing change, in their kind, number and arrangement. Groups of atoms which we call decomposition products are constantly given off from it and in return it receives from without other atom groups with which it regenerates its structure or increases its amount. All definitions of life convey the idea of activity. Aristotle says "Life is the assemblage of the operations of nutrition, growth, and destruction," Herbert Spencer "Life is the continuous adjustment of internal relations to external conditions." We know much about the elements which are contained in living matter and something about the substances which are formed by their grouping.

We know that the molecules forming it are large, complex and unstable, and as such constantly tending to pass from the complex to the simple, from unstable to stable equilibrium. What the atomic arrangement in the molecules is, how the molecules are grouped in their physical relations we do not know. It has not been found possible by physical or chemical action to combine the elements in such a way that the mass will exhibit those activities which we call the phenomena of life. As to the origin of life we only know that at some time in the past it appeared on our globe and since its appearance it has probably not ceased to exist, and has preserved those fundamental properties which characterize it. Certain conditions are essential for living matter. It must be surrounded by a fluid or semi-fluid medium in order that there may be easy interchange between it and the surrounding medium. It must constantly receive from the outside a supply of energy in the form of material which it can assimilate, and substances formed as a result of metabolism must be carried away. Living matter is associated with form. It occurs in the form of small masses, called cells, which vary considerably in form, structure and size. While it is true that cells alone show all the phenomena of life, certain substances found about them and probably formed by their activity certainly exhibit some of the phenomena. In certain of the living things the cell constitutes the individual, while in the higher animals numbers of cells are combined to form the organs and tissues.

Let us observe under the microscope one of the small unicellular organisms called an amœba. It first gives the impression of a gelatinous structureless mass, but on closer observation we see that the outside is finely, the interior coarsely granular, that it has a round vesicular nucleus only slightly differentiated from the general structure. The interior granules often change their position showing that there is motion within the mass. There is also motion of the entire mass and the whole moves across the field of the microscope. In the water with the amœbæ are other small organisms, particularly bacteria, on which they feed. We can see a bacterium taken into the body of an amœba where it lies within a clear space. After a time it disappears, it has undergone solution in the fluid contained in the space and is assimilated. The substances of which its body was composed have been changed, the molecules broken up, rearranged and a part has been converted into the substance of the

amœba. If we introduce insoluble substances such as carmine particles into the water, these are also taken up by the amœba, but they undergo no change and after a time they are cast out. Under the microscope we can observe only the grossest of the phenomena, the motion within the mass, motion of the mass, the reception of food particles and the discharge of inert substances. The chemical molecular changes we cannot see, nor can we see the interchange of soluble substances, such as oxygen and carbonic acid, between the amœba and the fluid.

We have supposed that we have been watching this amœba under conditions which may be regarded as favorable. Under these conditions it has been able to assimilate to grow and to multiply. Let us now observe what will happen when the conditions are more unfavorable. We will suppose that a drop of salt water be allowed to flow under the coverslip. Changes appear almost instantly. Movement ceases, the organism appears to shrink into a smaller compass, the whole structure becomes coarsely granular and opaque. If the amœbæ remain a sufficiently long time in the salt water they do not regain their usual condition on being returned to the fresh. None of the phenomena which characterized the living amœbæ are seen, they present no change, we say they are dead. By varying the length of the exposure to the salt water or its concentration we can reach a point where some, but not all, of the organisms are destroyed, a few or many individuals will survive. Exactly the same phenomena may be produced by the application of heat. We may vary the experiment in another may by adding daily very small amounts of sea water to a tank containing the amœbæ. It is possible to accustom the organism to new conditions and finally it finds conditions favorable for existence in pure salt water. But in the process of change many individuals will have perished. Organisms may in the same gradual manner be accustomed to degrees of heat much greater than they are usually exposed to.

This simple experiment teaches us much concerning disease. By subjecting living matter to conditions different from those to which it is accustomed, and unfavorable, such alterations may be produced, that it is not again capable of life when returned to usual conditions. We may speak of such changes as injuries or lesions. The alterations which we see are coarse and affect the mass, and before this degree is reached there

must be rapid changes going on which affect the molecular structure and which we cannot see. Just as in pathology the use of microscopic methods of investigation have enabled us to appreciate many changes in tissue which were not apparent to the naked eye, so we must realize that there may be changes in the arrangement or the structure of the living material, even changes which are incompatible with life, of which there is no microscopic evidence. In other cases the injury was only sufficient to inhibit for a time such forms of activity as alimentation and growth, and all activities returned when the organisms were placed under usual conditions. With the return of the usual activities or preceding this the organisms if visibly altered regain their usual form and structure. It would be perfectly proper to speak of this as disease and recovery. Observe that the disease was due to the influence of external conditions, which were unfavorable to the chemical interchange taking place between the substances of which the cell is composed. Whether the effect be produced by change in osmotic pressure between the cell and the surrounding medium or by the destruction of ferments or by the introduction into the cell of substances which form stable chemical union with some of its constituents the result is the same. The experiment also shows us that the living matter is adaptable. Under the influence of unusual conditions variations in structure, and by structure I do not necessarily mean the coarse physical structure which we can recognize, and possibly in substance, may take place so that the usual activities may still be carried on. Think of what an enormous change it means when a fresh water organism is subjected to the molecular pressure of salt water. We cannot think of an organism becoming adapted to such a change without undergoing vast changes in structure whether we are able to recognize the changes or not. The organism will not be diseased in spite of the change or lesion, if you will, provided if in consequence of this the harmony with the environment be not impaired. An individual without a liver should not be regarded as diseased provided there could be such internal adjustment that all of the vital phenomena could go on without the aid of this useful and frequently maligned viscus. Change alone is not essential to disease, and it is only by means of changes which take place that an individual combats and overcomes disease. Think of what takes place in the recovery from an infectious disease, and try to comprehend all the immense and unusual cell activities without the supposition of profound change. We do not know whether all these changes are recovered from, whether the slightly injured amœba when returned into fresh water is ever just the same amœba although all its activities may go on in the usual manner, and the usual action determine the usual reaction.

For many reasons we can arrive at simpler conceptions of life from the study of the more complex organism. The one cell of the amœba does everything. In the complex animal, function is divided among many organs which can be studied separately. Here we know there can be changes induced in various ways which are to a greater or less degree permanent. An animal immunized against a foreign serum will continue to react against the serum for a period the duration of which varies with the individual. In such an animal we can discover no change in the character of its tissues by the most careful microscopic and chemical examination and yet there must be change to enable the formation of antibodies to take place on the stimulus of a foreign serum. Even if we suppose the reaction to be one of education of the cells in consequence of which the tissues which at first produced the immune factors slowly now at once react in the unusual way to the stimulus, this presupposes some change in the substance acted upon.

The experiments have also shown that the units of living amœbæ are individual. In the degrees of exposure some, but not all the organisms, were destroyed, in the slight exposure few, in the long many. We can speak in a general way of conditions which are incompatible with life in this or that genus but the unfavorable conditions for this must be extreme. It is extraordinarily rare for any disease in animals or plants to destroy all individuals of a species equally exposed to it. Even in the very simplest forms of life, such as the bacteria, we see the same results. The individuality becomes more marked as we ascend the scale; lately we have learned of individuals whose blood serum is hemolytic for the corpuscles of the same species. Individuality is also strongly marked in the resistance to disease. In the case of resistance to infection we must be guarded for it is almost impossible to suppose two individuals to be equally exposed to the action of the same amount of virus, of the same virulence and introduced in exactly the same way. An epidemic may to a certain extent be considered as a battle in which the flying bullets

find an occasional mark; in other words chance may decide. In testing in animals susceptibility and resistance to infection we meet marked individual variation and no two tests can be exactly alike. Still there is enough to show that there is in man great variation in the degree of resistance to an unfavorable environment. Every tale of shipwreck and exposure shows this. No unfavorable environment can be regarded as a cause of disease unless it suffice to overcome this physiological resistance, this capacity of the living material to adapt itself to an unusual environment. For certain individuals then the unfavorable environment will constitute a cause of disease, for others not. The individuality of living matter has always seemed to me one of its most marked characteristics. It we take a flask of microorganisms although exactly alike microscopically, in various ways, even in our coarse testing by bactericidal substances we find marked differences. If, on the other hand, we take a mass of sugar grains, each grain will show just the same characteristics, will react in exactly the same way as all the other grains of the mass. The extraordinary complexity of the substances which form living matter, and the complexity of intermolecular arrangement, might admit of very considerable variation without morphological evidence, and to such variation in structure individuality must be due. It would seem further, that acquired differences in structure under the influence of unfavorable conditions and by means of which the individuals are able to resist them are inherited. In Dallinger's experiments on the action of heat on unicellular organisms, he was obliged to proceed with the utmost slowness in varying the temperature. Several weeks of cultivation at a certain temperature were necessary before the culture could be raised an additional degree. It is very probable that the resistance to heat was net acquired by individuals but that multiplication constantly took place from organisms in which heat resistance represented a natural variation. Almost certainly, but to what degree we do not know, man has acquired by inheritance some resistance to infection. We know that resistance to other unfavorable conditions is inherited as in the case of the resistance of the Esquimo to cold.

No other living thing is probably so resistant to the variations of environment as is man. To this resistance he owes his supremacy. It is not only that he is able to resist an unfavorable environment, but by

means of his intelligence he changes the environment. He is able to resist the low temperature by means of houses, fire, clothing, etc. In certain cases he is able to destroy within the body microorganisms whose presence and growth produce conditions unfavorable for the activities of the living cells. In rarer instances he is able to bring about in the tissues the changes which will enable them to resist the microorganisms, and in still other cases he is able to destroy the microorganisms outside of the body or to protect himself from their attack. In still another way can man do something to ward off disease. Just as he can acquire disease by an unfavorable environment he can so adjust the environment to an injury that harmony will result in spite of the injury. Thus an injured arm would not be a disease provided that the individual did not play golf or work in the garden or in other ways so adjust his environment as to call for no function of the injured arm. It is curious how narrow the environment sometimes becomes which is necessary to compensate for an injury. For an individual with an uncompensated heart lesion the ordinary free life and work becomes narrower and narrower until the only environment in which life is even tolerably harmonious is between blankets and within four walls.

The various causes which act on the organism producing the changes which are necessary for disease must of course be manifold. Any unfavorable condition, any condition to which the particular organism is not by structure adapted, can be a cause of disease. Further it is evident that all causes of disease must come to the organisms from without. There are no internal causes of disease, every agent producing injury acts from without. Of course this is evident in regard to the infectious diseases. Here the living thing which constitutes the virus finds within the tissues of the body favorable conditions for life. There then takes place a struggle for existence between two living things. In this struggle we are too apt to consider only the changes which take place within the host which in favorable conditions lead to recovery and immunity. We know the changes which take place in the serum and the cellular changes shown in the formation of the phagocytes. But the infecting organism is a living cell probably as complicated in structure as any of the body cells and it too may undergo changes in the body. Just as the body cells become changed in the struggle with the parasite so the parasite may undergo changes which will enable it better to withstand the unfavorable environment which the host seeks to produce. We find even coarse morphological changes in the parasite shown in the formation of capsules which prevent the action of the destructive serum of the host. The parasite may also meet the destructive chemical substances produced by the host by the formation of substances equally destructive. Of course if the action of the parasite is dominated by the conscious desire of getting all that it can out of life for itself and immediate descendants, it will seek the friendly relations with the host which are seen in symbiosis, rather than the host's death. For many parasites the death of the host carries its own destruction; like Samson it perishes in the fall of the temple. Such an obligate parasite as the tubercle bacillus finds its conditions for existence in the living and not in the dead body. Parasites like other living things must, have a wide range of adaptability to environment, a resistance which can be increased. The natural variation may be especially marked in the direction of resistance, those individuals which survive being the progenitors of continually more resistant offspring. The increase in virulence which an organism may be made to acquire by continually infecting animals with it may in all respects be likened to accustoming the amœba to variations in the osmotic pressure of fluids and to the effects of heat. The whole subject of infectious disease is so fascinating that there is a temptation which few can resist to linger long upon the subject. In the first place it is a subject on which we can erect our hypotheses the truth or falsity of which may be shown by experiment. This knowledge has been applied in a way that no other knowledge has been found capable of application to the prolongation of life, to the furtherance of human efficiency, to the increase of human happiness. The knowledge which we have obtained has been further of immense service in stimulating research and discovery in biology, for the problems of disease are essentially biological problems dealing merely with the reactions which living things show to their environment. I cannot leave the subject without dwelling for a moment on one aspect which has not generally received the consideration which it deserves. It is well known that the infectious diseases are diseases of early life. Deaths from them generally occur before the age of 40 and in some cases, as in the so-called infectious diseases of children, very much earlier. There are very many factors related to age which com-

bine to bring this about. In the first place animal experiments have shown that young animals are less resistant to infection than are old, the young of certain animal species are susceptible to infections towards which the adults are immune. While this may be one of the factors influencing the relation between age and infection it is far from being the only one and may be the least important. So far as I know there is no infectious disease which may not appear at any age. All forms of tuberculosis, typhoid, measles and whooping cough are seen, though rarely in the aged. One factor of great importance is the immunity more or less pronounced which is produced by one attack of an infectious disease so that the old are to a great extent protected from infection through the immunity conferred by an attack in childhood or youth. Another factor of importance is the variation in exposure due to habits of life, occupation, etc., which differ at the different ages. There is very little infection up to the first year. The nursing infant has a small range and very limited contact with the external world. With the advent of school bringing with it such wide opportunities for infection through the close intermingling in school and in play of the child with its fellows there is a sharp advance in the incidence of infection. This is clearly shown in the relation to age of such diseases as scarlet fever, measles and diphtheria. There has been a wonderful change in this respect in regard to small-pox which in the prevaccination days could be considered a disease of childhood; now with the introduction of compulsory vaccination in the public schools the incidence of the disease shows, instead of a rise, a sharp fall when the school age is reached. Factory life in which chiefly young adults, and unfortunately too often children, are engaged acts as the school in giving opportunities for infection. The very definite relation between tuberculosis morbidity and density of population is due chiefly or entirely to the greater opportunity for infection which the closer contact brings.

It is in the infectious diseases that we have obtained by scientific methods, knowledge which has been applied with great success to their control. All factors in modern civilized life, the crowding of the people into towns, the enormous increase in communications everywhere so work to the increase of infectious diseases that without the modern control such life would be impossible. And in spite of this the curve of practically every infectious disease shows a marked downward tendency. To mention only two diseases in which the decline has not been the

most conspicious, tuberculosis in Massachusetts shows a decline from 39.5 deaths per 10,000 in 1857 to 15.6 in 1905, typhoid fever a decline from 6.6 deaths per 10,000 in 1875 to 2.8 in 1905. The appalling mortality of children under five has been reduced from 34.79 in 1867 to 29.24 in 1903. There can, of course, be but one result from this. There must be a corresponding increase in the number of individuals in the community who have reached the age of 40 and beyond. Taking the actual figures of the census report we find that in Massachusetts the ratio of persons over the age of 40 years to the entire population of the State has increased from 22 per cent in 1850 to 28.6 per cent in 1905. There is no doubt that progress in surgery has also contributed powerfully to this result for the majority of conditions for the relief of which surgical proceedings are instituted concern individuals under 40.

Recently articles in the daily press and in medical journals have called attention to the apparent increase in certain diseases. These diseases are the organic diseases due to changes in the organs interferring with their proper function and certain tumors such as carcinoma. Now all study of the relation of age to disease has shown that these are the diseases of later life, certainly of the age past 40. The question is, have these diseases actually increased or is the increase due to the fact that more individuals reach the age when the diseases are most apt to occur? It would be of the greatest importance to find out if there is an actual increase in the incidence of cancer. The English statistics, which are probably the most reliable, show that of individuals over 35 years of age the chances are that of males 1 in 11 will die of cancer, and of females 1 in 8. The returns of the registrar-general of England for 1906, giving in a total death of males over 35 years old of 141,241, 12,695 deaths from cancer, and of 140,607 deaths in females over 35 years, 17,671 deaths from cancer. Turning again to the mortality statistics of Massachusetts the curve of deaths from cancer ascends from 2.1 deaths per 10,000 in 1857 to 8.4 in 1905. Such statistics appear absolutely appalling and if there were such an increase in the disease as would appear from the bare statistics all of our energies should be enlisted in the combat against the disease; for with such an increase cancer would bid fair to cut short human existence after 40. Massachusetts does not stand in an exceptional position in this regard for all the register states show about the same figures, some a little above, others below. Many factors enter into

the problem, the predominant one being the general increase of age giving greater opportunity for the disease, more inflammable material, more frequent fires. There comes in, however, greater accuracy in diagnosis which we have now and which accuracy by the use of new and more exact methods of investigation constantly increases. This applies particularly to cancer in the internal organs in which the greatest increase occurs. Moreover there is not the same attempt as formerly to conceal cases of cancer, owing to it being thought formerly from the supposed heredity of the disease that the family prestige would suffer from the fact being known. Even where we obtain what is apparently exact information there may still be much doubt in the interpretation of the figures. The general census report of 1890 and 1900 giving the number of deaths from cancer at the different ages shows a marked ascent which can be accounted for, to what extent no one knows, by the increasing accuracy in the recognition of cancer cases. The more highly trained the medical service of a community, the more accurately the vital statistics are recorded, the higher the percentage of cancer deaths. All the statistics mentioned take into account the deaths from cancer alone. The statistics of cancer incidence would be very greatly increased if we took into account all the recoveries after surgical operation for cancer. It would seem as though there must be an actual increase in the disease though to what extent it is impossible to say. What I have said about cancer holds equally for diseases of the heart and vessels, and other organic diseases; in some, however, the apparent increase is much greater than in others. At first sight the organic diseases seem to differ in a marked degree from the infectious diseases. They are, as the name implies, diseases of organs primarily although in none of them do we find the disease confined to an organ. So intimate is the interdependence of all parts of the body, so dependent is the whole on the integrity of the parts that a disorder in one part throws the machine to a greater or less extent out of gear. The damaged organ may not perform its part in eliminating or changing substances which are injurious to the tissues and in consequence of the disordered action substances may be formed which are injurious. We easily see this interaction in cases of disease of the heart but it is equally true though less obvious in disease of the liver and kidneys. That these diseases are most marked in individual parts does not of itself sharply separate them from the infectious diseases for with these it is only in rare instances that

the entire body seems equally affected. There is as a rule localization and from this point the infection may or may not extend. The localization may be determined in one case by the organism which causes the disease finding in certain tissues only an environment which is adapted to its life, or the localization may be determined by the change of the mode of entry of the organism into the body. The chief difference is that we are not able to trace the direct origin of the organic diseases to the action of a living germ coming from without. As we have said they are chiefly the diseases of the latter half of life but by no means exclusively so. A careful study of children's autopsies shows an astonishing amount of organic disease before the fifth year. The indications of disease as shown in disordered function develop slowly and the disease takes a chronic course. The most light is thrown on the organic diseases by the close study of the organs derived from autopsy. In this way we learn that it is the exception rather than the rule to find organs free from disease in individuals over 40. The damage may be slight and only revealed by a most careful microscopic examination or it may be extensive. How these slight damages arise we become aware from the study of infections. Probably the slightest infection never passes over without producing a greater or less amount of damage in organs which are remote from the primary seat of the infection. The damage is in part repaired, never wholly made good, although no altered function, at least none apparent to our coarse methods of examination, gives indication of its presence. There is a wide range in the activity of organs, every organ can be called upon to do a greatly increased amount of work over that needed in ordinary conditions. A large amount of liver or kidney may be destroyed and the organ continue to do perfect work, a valve of the heart may be seriously damaged but the blood pressure will remain at the normal. This physiological resistance has been most felicitously expressed by Meltzler as the factor of safety. But this must be borne in mind. Every inroad made on that factor of safety reduces it. A man may easily carry 30 pounds up a hill, but if this load be permanently fastened upon him an additional weight is not easily borne. Every succeeding injurious action on the damaged organ produces a greater degree of injury than it would on the normal and another important factor, the power of regeneration, the capacity of repair, diminishes both with age and its more frequent exercise. As a result we have organs whose adaptability becomes more and

more reduced until the time comes when their utmost capacity for work is insufficient to meet the demands made upon them. Of course organs do not suffer equally although we not infrequently find cases in which every organ of the body shows a greater or less degree of damage. To these effects of injury must be added the increased work upon organs which advancing years bring. Life becomes on the whole less hygienic, there is greater tendency to excess in eating, which is not counterbalanced by increase in muscular activity, habits to which in youth the organism easily adapts itself are now felt as sources of injury. The end comes usually as the result of an infection which would probably have no effect on the unimpaired organism. The weakened body easily becomes the prey of the organisms seeking to devour it and against which in its integrity it successfully contended just as the wounded or weakened animal under natural conditions becomes the prey of its enemies.

The question of organic disease is so intimately related to age that this claims some attention. Is old age to be regarded as a disease? Yes and no. As we see autopsies on the aged we find that death is in the vast majority of cases due to diseases of organs, especially of the blood vessels of the body. The effects of repeated injuries become cumulative, vulnerability is increased and the capacity for repair is almost lost. We do, however, occasionally find cases in which the tissues seem worn out. There is undoubtedly a duration of life of tissue, especially of the intercellular substance, which can reach its end. When the tissues reach their end is largely determined by their individuality. We find some analogy for the part which the intercellular substances play in the aging of plants. There is no wear-out of the active cells of a tree. All the Baldwin apples over the world, all the Concord grapes which are growing, are simply parts of the original tree and vine which the kindly soil of Massachusetts gave the world. The individual tree dies only from the decay of the parts without active cells which in a way correspond to our intercellular substances. When the formed, noncellular tissue resists decay as is the case with the Sequoias, life seems to be everlasting.

In still another way does the increased duration of life affect us. There must be an increased amount of the human wreckage which fills the almshouses and the insane hospitals. More individuals will inevitably attain the age when they are no longer capable of self-support and must be taken care of, there will be a continual increase of those forms of in-

sanity which are due to the so-called senile degenerative conditions of the brain. The statistics of admissions into hospitals for the insane show this but there is some counterbalancing owing to the fact that our greater care for these unfortunates brings into the hospitals many cases formerly badly cared for in their homes.

So far in speaking to you of disease I have made no mention of the so-called functional diseases. How do these come into the general scheme? Well, for the pathologist there are no functional diseases, so the definition of disease which I have given you does not shatter on this rock. In regard to these so-called functional diseases we must be careful to remain on solid ground. If we forsake this there is great danger of falling into water which is clouded by metaphysics, for in the functional diseases we have chiefly to do with that very complex organ the nervous system. There is no reason to doubt that the living matter constituting this differs intrinsically from any other sort of living matter. Like other living matter the reaction which it gives when acted on is due to its composition and structure considered in the widest sense, and the character of the action exerted upon it. Owing to its complexity not only are changes more easily produced in it but there is greater probability of variation in structure. The variation in higher animals which gives the strongly marked individuality is apparent chiefly through the action of the nervous system. Homologous twins may show extreme similarity in size and form, but the individuality is there nevertheless. Now in these so-called functional diseases an action of a certain sort may produce an unusual reaction which for instance may find expression in a sense of pain and discomfort. We examine and we find no condition which in the vast majority of cases would alone suffice to give rise to the impression on the pervous system which is interpreted as pain. The same impression under usual conditions might not be sufficient to excite consciousness or if so would be interpreted in a totally different way. Here there may be change all along the line, in the sense organs, in the paths of conduction, or in the central organ. It is not even necessary to assume that the fundamental condition is a congenital structural difference. Changes can easily be produced. It is perfectly possible that substances of an unusual character or an excess or deficiency of usual substances in the fluids around brain cells may so change them that these unusual reactions appear. There may be very marked individual susceptibility to such an unusual action of the cells. It is even possible that the constant repetition of stimuli of an ordinary character may produce sufficient change to give rise to unusual reaction. We know into what a condition one's nervous system may be thrown by the establishment of a boiler factory near one's home, or by the work of a plumber in one's house. Even the confused and disagreeable sounds due to the clatter of high-pitched women's voices, which one hears at teas and receptions, may, when frequently repeated, be productive of changes sufficiently marked to give rise to the unusual reactions which give evidence of disease. It is not even necessary for the reactions to have those interpretations which we associate with disease. May not many of those forms of activity which unfortunately are too often found in women and which we are apt to designate by the term pernicious, and their general restlessness be simply a form of disease, of functional disease if you will?

Insanity is a disease of the brain just as surely as malaria is a disease of the blood. We have among the diseases of the brain those with as definite an anatomical basis and as definite symptom groups as we have in typhoid fever. It is probable that we never will arrive at as definite a classification of these diseases as we have in the infectious diseases because we have not single etiological factors as the basis of a classification. Unfortunately much confusion has arisen from the fact that the symptoms of these diseases, the reactions which the injured brain cells give, differ so much from the usual reactions, that the symptoms have received the most attention. The study of the abnormal reactions is interesting and may even throw some light on normal function as the physiologists have found the study of abnormal action important for the comprehension of the normal. It must, however, be remembered that the most light is going to be thrown on the diseases of the brain applying to them the same anatomical and chemical and bacteriological and experimental methods which have given success in the diseases of other organs.

And now you are about to enter upon a life which will bring you into intimate relations with all the aspects of the complex conditions of disease. You are going to come in contact with humanity in its best and its worst aspects, for disease strips off the conventional outer covering and the moral nature is laid bare. You are entering the most altruistic of professions, one in which the best efforts of its members are directed todard the physical and moral betterment of the race. If philanthropy be

evinced in deeds of practical beneficence affecting the race then Jenner, Pasteur, Koch, Ross and Reed, to mention only a few names, have been the greatest of all philanthropists. The world knows as such only the philanthropist who gives money out of his superabundance which is after all a most uncertain way of benefit. However, you need not concern yourselves about this form of philanthropy for it is almost impossible that it should come in your way to exercise it. You must make up your minds at the beginning that your life is going to be arduous, that there are few prizes, that the road to even that degree of financial success which will enable you to establish a home and family in comfort is now and is becoming increasingly difficult. The great reason for this is that disease is being more recognized as the chief of the social problems, that it concerns not only the individual, but the masses. The measures directed against it must act on the masses. To this end we have hospitals, dispensaries, and boards of health which are daily becoming more efficient. This movement is not going to diminish but will extend, tuberculosis is being more and more removed from individual medical care and the great success which has attended the modern measures of caring for tuberculosis will be extended to other diseases. All measures directed against the extension of disease by school and factory inspection are social measures and diminish the importance of your efforts which concern the individual. One of your duties will be to so educate the individuals, with whom you come in contact, in knowledge of disease and of the factors leading to it, that these social measures can be made effective. As some offset there will be an increasing demand for physicians who will be employed in a public capacity, an increasing number of positions in institutions of various sorts. It is of the utmost importance that you should utilize every opportunity for the study of the diseases of age for these are the diseases you will chiefly be called upon to treat. Remember that your preparation so far has been to give you a foundation on which you can build. You must now begin to acquire knowledge by independent observation for this is the only knowledge that profiteth. Success will always come to the rare individual who under all circumstances does his best. He will do his best in that direction in which he has the most joy in the doing. Do not be afraid. There is an abundance of work to do, and room in the world, and food, and water and raiment for the honest worker and the greatest happiness lies in work.

#### THE FILTRATION OF MILK.

#### BY O. B. SCHIER.

Milk, one of the most important of human foods, is unfortunately also one of the best culture media for almost all known germs. Ever since this has been recognized it has been the main aim of science to prevent the contamination of milk by germs. For this reason the connection of a bacteriological laboratory with the larger daries seems to be a step towards this end, but the smaller dealer could hardly afford the expense of such a laboratory. However, occasional bacteriological tests of each farmer's milk, made by a competent bacteriologist, the results of which are reported to the farmers, will in course of time open the farmer's eyes to the importance of cleanliness.

Proper instructions not to mix the foremilk with the whole milk; in regards to the elimination of the stable dust; the careful cleaning of the udders and flanks of the cows; cleanly hands of the milkers; the milking into covered pails, or pails with small openings; the cleanliness of the utensils; the supervision of the employe's health, etc., followed up by frequent personal inspection trips will do a great deal towards improving the bacterial contents in milk.

Unfortunately in Maryland we find it almost impossible to make the average farmer use a pail with a small opening, and I am afraid it will be a long time before we can induce him to do so generally, therefore, most farmers are using a strainer to take out such visible dirt as can be eliminated by a double piece of cheese cloth. It has always seemed to me that instead of improving the milk, the strainer only acts as a cause of infection.

Dr. C. Hampson Jones, the the assistant commissioner of the Department of Health of Baltimore, has been kind enough to have our city bacteriologists, Dr. Royal Stokes, make a number of bacteriological tests of milk before and after straining, the ordinary way now prevailing in Maryland, and presumably most everywhere else. These tests showed invariably a great numerical increase of bacteria in the strained milk compared with the milk before straining.

In one instance the unstrained milk contained 20,000 bacteria to the cc., while the straining through a strainer with a fine metal gauze, such

as is commonly used, with two thicknesses of apparently clean cheese cloth, increased this number to 300,000 per cc.

We all realize that the ideal way is to prevent dirt from getting into the milk, but we, in Baltimore, are, so to speak, up against the conservatism of the Maryland farmer, as it pleases him to call his unwillingness to adopt new and better methods.

For years we have, therefore, looked for a material that would strain milk better than the cheese cloth. Absorbent cotton we found unsuitable to be used by the average farmer on account of becoming too quickly clogged and being too easily torn when placed into the receptacle, besides necessitating still the use of some metal strainer for its support.

The ideal filtering material should be strong and self-supporting; it should have large quantitative and qualitative efficiency, and most of all should not be too expensive, as it will rest in most cases with the dealer to supply the farmer with the cloth at his expense if he wants to be at all sure that the farmer is goin to use it.

After many years of experimenting with different materials, Johnson & Johnson, of New Brunswick, finally made for us a very carefully woven and especially carded "Absorbent Lint," which they now sell under the name of "Red Cross Filter Cloth for Milk."

We have supplied each of our farmers with a receptacle like the little minature model I have here, and in which the absence of a strainer is conspicuous. It consists of an outer shell, a deflecting plate to break the fall of the milk when poured into the receptacle, and a ring to fasten the filter cloth. In the instance cited before, half of the milk, the bacterial contents of which was so greatly increased by the usual method of straining, was run through a piece of Red Cross Filter Cloth, and its bacterial contents was reduced from 20,000 to 10,000 per cc., and upon a second filtration through a new disc not a trace of dirt could be found on this second disc.

These results have been borne out by the clean milk of a uniformly nice flavor which we now receive since we have made the use of this filtering cloth compulsory. We furnish each farmer with 65 discs each month, and he uses a new one at each milking. For our larger producers we use a 9-inch square and a somewhat modified receptacle.

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## THE JOURNAL

### OF THE ALUMNI ASSOCIATION

OF THE

# COLLEGE OF PHYSICIANS AND SURGEONS, BALTIMORE.

THE ALUMNI MEETING AND CLASS RE-UNION OF '95.

Once again the old P. & S. closed its collegiate year with graduating exercises. The class numbered 66 men, five students had withdrawn before the examinations and five members of the class failed to pass the examinations.

The exercises this year were of special interest as they served in a measure to celebrate the 15th anniversary of the class of '95. A year ago we expressed an opinion that class re-unions were not a success; but we are prepared to retract that statement and admit that the re-union of '95 was a decided success and are encouraged to stimulate efforts on the part of other classes. Dr. Harvey G. Beck is engineering a re-union of '96 and it is hoped that 1901 will also gather its forces.

On Wednesday, June 1, the annual Alumni meeting was held in the college building. The boys of '95 began to arrive early and its was delightful to meet them; for a while there was quite a guessing contest as to who was who. Some, who had worn fierce whiskers in college days, were without hirsute adornment; those who had been without had developed artistic whiskers. Many had grown stout and some were bald. All looked prosperous and happy.

There was Bowerman from Buffalo; Stetson from Greenfield, Mass.; Shirey from York, Pa.; Yagle from Red Lion, Pa.; Hadley from Walden, N. Y.; Shatto from Pipersville, Pa.; Peery from Bluefields, W. Va.; Vogel, U. S. M. H. S., from Reedy Island, Del.; Wickline, U. S. M. S., Washington, D. C.; Tarter from Iron River, Wis.; Bruner from Hynd-

man, Pa.; Finch from Champaign, Ill.; Morehead from Lasker, N. C.; Murray, Scudder, Savage, McGlannan and Brack of Baltimore.

At 8.30 the faculty, alumni and the graduating class assembled in the amphitheater. Dr. E. A. Bowerman, '95, introduced by Dr. Brack, read a scholarly and extremely interesting paper treating the newer aspects of certain functional diseases of the nervous system, dwelling chiefly upon the condition termed neurasthenia.

Dr. Bowerman was accorded a rising vote of thanks and highly complimented upon the excellence of his paper.

Alumni business was now taken up, and the treasurer reported a balance in 1909 of \$59.48. Receipts for the current year \$862.75; expenses \$842.39. Total balance \$80.39.

The class of '10 was then elected to membership in the association. The officers for the year, unanimously elected, are: Dr. E. A. Bowerman, '95, president; Dr. Roy W. Locher, '10, 1st vice-president; Dr. John W. Chambers, '78, 2d vice-president; Dr. H. K. Fleckenstein, '04, secretary; Dr. Chas. E. Brack, '95, treasurer.

Publication Committee: Dr. Wm. S. Gardner, '85, editor; Dr. John Ruhräh, '94, associate editor; Dr. Chas. E. Brack, '95, business manager and treasurer.

Entertainment Committee: Dr. A. C. Gillis, '04; Dr. H. K. Fleckenstein, '04; Dr. W. D. Wise, '06.

The sad announcement of the recent death of Dr. W. R. Howard, '79, of Rochester, N. Y., who had been elected president of our association in 1909, was then made. Dr. Howard had intended to be with us and preside at the meeting; his death occurred on the Friday previous after a short illness. He was one of the leading medical men in his city and one of the most lovable of men. His sudden death was a great shock to his associates and friends, who admired and loved him.

As there was no further business the meeting adjourned.

A smoker and lunch was provided and arranged for in the lower lecture halls. Among the alumni present were: Dr. W. P. McIntosh, U. S. M. & P. H. S., '82; Dr. Geo. A. Strauss, '83; Dr. H. B. McDonnell, '88, College Park, Md.; Dr. T. J. McBee, '05, W. Va.; Dr. John Folk, '04, W. Va.; Dr. F. C. Schumacher, '05, New York; Dr. C. G. Hildebrand, '81, Logansville, Pa.; Dr. W. C. Fogle, '96, W. Va.; Dr. John H. Doyle, '02, W. Va.; Dr. Alfred Gundry, '94.

After the smoker the class of '95 was entertained by Dr. McGlannan at the University Club; and had a most enjoyable time recalling college incidents and class associations.

Thursday morning was spent in inspecting the college and hospital buildings and noting the extensive improvements and modern equipment. At 10.30, Dr. N. G. Keirle gave a demonstration of the Pasteur treatment, which was greatly appreciated. At 12 m. luncheon was served at Hotel Junker and at 1 p. m. automobiles carried the class of '95 and friends through the beautiful suburbs of Baltimore by way of Roland Park and the Green Spring Valley, arriving at the Maryland Country Club for afternoon tea. A souvenir photograph was taken at the club.

At 8.30 the '95 boys appeared upon the stage of the Lyceum in cap and gown for the commencement exercises as they did 15 years ago, but passive instead of active participators.

The oration was delivered by Dr. Wm. T. Councilman, of Harvard; Dr. Wm. Simon awarded the prizes, and Dr. Chas. F. Bevan conferred the degrees.

The annual banquet was held at the Rennert at 10.30 p.m. The class of '95 were seated together at one table and the vigorous class yell, which was heard from time to time, showed that while years may have brought responsibilities and cares yet they were still the boys of '95. Dr. McGlannan, as toastmaster, was extremely entertaining and witty.

Dr. Harry Friedenwald, in the absence of Dr. C. Hampson Jones, responded for the faculty in a manner most complimentary to the faculty.

Dr. Harold Longsdorf, the class valedictorian, predicted the fate of '10, and gave promises of what the class of '10 was going to do.

Dr. Standish McCleary addressed words of wisdom to the graduate students and made an original classification of the faculty.

Dr. Halbert G. Stetson, '95, reviewed the history of '95 and of some of its members. He made the unqualified statement that it was the best class ever graduated in the P. & S. and recognized early as such by the faculty, who at once arranged to keep the class for three years instead of two and also increased the tuition fees. No man made a mark less than 100 and caused the faculty great concern in awarding prizes and honors. All the men have since distinguished themselves and we regret that lack of space prevents us from mentioning in detail the achievements of the

class of '95. Drs. Morehead and Bruner then served a loving cup to the members.

Dr. Chas. F. Bevan, our dean, responded to the call of the toastmaster and contrasted medical education and the medical college of the past with that of the present. The star system of medical teaching has passed and the results are obtained by the hard and efficient work of a large number of trained men. The strength of the college rests in its adjuncts and associates.

College prizes were awarded to the following: Roy W. Locher, Ohio, first prize, gold medal; Harris Goldman, Md., second prize, gold medal; Wm. B. Hunter, W. Va., third prize, gold medal; W. D. Blankenship, Ohio, fourth prize, gold medal.

The following were worthy of honorable mention: Harry L. Brehmer, Ohio; Benj. L. Naiman, Md.; Thos. F. Keating, Conn.; J. H. Walsh, Mass.; F. H. Sissler, W. Va.; W. G. Harper, W. Va.; J. G. W. Schafer, Ohio; G. C. Blake, W. Va.

The Mercy Hospital appointments were as follows: Medical superintendent, A. C. Gillis; resident gynecologist, Harry L. Brehmer; resident pathologist, A. B. Eckhardt; resident obstetrician, J. H. Rippert; assistant resident physicians, W. W. Hobson, B. A. McCleary, G. C. Blake, E. S. Stambaugh; assistant resident surgeons, O. L. Lloyd, F. A. Duvally, H. E. Longsdorf, E. T. Quinn.

The graduating class for 1910 is as follows:

Davisson, Ithamar..West Virginia
Duvally, F. A.....Massachusetts
Finkelstone, Benj. B.....Conn.
Fisher, Julis R......Ohio
Fleming, Frank P......N. B.
Fox, Lorah O....West Virginia
Froitzheim, W. J.....New York
Giorgessi, Joseph ...Pennsylvania
Goldman, Harris .....Maryland
Grisinger, Geo. F...West Virginia
Grounds, W. L....Pennsylvania
Hanrahan, James M.....Conn.
Harper, W. Glenn..West Virginia

Higgins, Gregory L. . Pennsylvania Hobson, W. W.....New Jersey Holroyd, Fred. F...West Virginia Hunter, Wm. B....West Virginia Kahle, Gail W......Maryland Keating Thomas F...Connecticut Kimsey, John A.....Michigan Laham, Nedim T.....Syria Locher, Roy W.....Ohio Longsdorf, Harold E.....Penn. McCleary, Benjamin....Maryland McDede, E. H.....New Jersey McGinn, James F...Rhode Island MacMillan, H. A..... Montana Maxson, Chas. W.... New Jersey Maysels, Alexander ......Penn. Moore, L. H.....Pennsylvania Naiman, Benjamin L......Md. Newell, J. O..... North Carolina Noland, Edgar B......Virginia

Powers, John T..... Nova Scotia Quinn, Elwood T...Pennsylvania Rippert, James A..... New York Roe, Theron E....South Carolina Sayre, Conrad F...West Virginia Schafer, J. G. W.....Ohio Seidel, Herman ..... Maryland Seymour, Geo. A.... New Jersey Shillingburg, E. P. . West Virginia Sisler, Franklin H........W. Va. Skilton, A. Wadsworth....N. Y. Smith, Arthur C.... Connecticut Stambaugh, Elmer S.....Penn. Steinke, Frank ..... New Jersey Sweeney, John J...Massachusetts Toomin, Emanuel ..... Maryland Trent, Letcher E. . North Carolina Tuckwiller, Jesse R......W. Va. Urbanski, N. A. J..... New York Walsh, James H.... Massachusetts

# THE NINTH ANNUAL COMMENCEMENT OF THE MERCY HOSPITAL TRAINING SCHOOL FOR NURSES.

The Ninth Annual Commencement of the Mercy Hospital Training School for Nurses, took place on the evening of May 24, at Loyola Hall.

The Dean of the Faculty, Dr. C. F. Bevan, congratulated the fortunate young ladies, who, out of a large class, had persevered through the difficulties of training and at last were worthy of graduation; he then introduced Rev. P. C. Gavin, Chancellor of the Diocese, who, by many well chosen scriptural texts, highly ennobled the duties of a nurse, advising her while relieving the bodily ills, to direct the mind to higher and holier motives.

Dr. Harry Friedenwald, the orator of the occasion, most eloquently compared the better trend of society to the care of others with the love each bears himself. Most vividly he pictured instances in which even royal personages were allowed in past ages to suffer much, which could have been avoided, while in our days, through the ever watchful care of

the nurse, the most abandoned may be comfortable while ill. By a beautiful comparison the vestal virgin was shown to be highly honored on account of her life and good works, so likewise the trained nurse shall be honored wherever she goes, if she be faithful to her high ideals.

Diplomas were awarded to: Misses M. Loretto Kelly, Cordelia Little, F. Nila Tucker, Elizabeth Chapman, Mary Loretta Dowling, Ida Davis, Teresa Stromberg, Mathilda Scheuer.

The gold medal for excellence in theoretical and practical nursing, was awarded to Miss Mathilda Scheuer.

#### THE NEW MERCY HOSPITAL.

The New Mercy Hospital, adjoining the present location, is beginning to make its appearance above ground. The successful formation of the reinforced concrete in the extensive foundation, of necessity required a long period of time, but this having been finished, it is hoped that in a very short while the much-needed improvement will be in operation.

The structure, when finished, will have many well-planned features which will greatly facilitate the modern treatment of disease.

Several laboratories, new operating rooms, dressing rooms, duty rooms, etc., are designed for the convenience of the medical and surgical staffs.

The private rooms for patients will be greatly increased in number, many having private baths adjoining. The monotony of the long corridors will be lessened by brilliantly lighted sun parlors made cosy and inviting by restful couches.

### Obituary.

DR. MAX BRUCK, of Newark, N. J., died in Morris Plains, N. J., October 18, 1909, aged 38.

Dr. Samuel T. Haffner, '74, a member of the American Medical Association, and once president of the Frederick County Medical Society; for several terms health officer of Frederick County and physician of Montevue Hospital, Frederick; elected clerk of the court in 1903, died at his home in Frederick, May 6, from angina pectoris, aged 61.

Dr. William Jacob Points, Washington University, Baltimore, '52, a practitioner of Mount Crawford, Va., until 1865, when he adopted the

profession of law, clerk of the circuit court of Albemarle County, from 1869 to 1870, clerk of the federal court, Staunton, Va., till 1875, United States commissioner from 1871-1883, and for several years thereafter commissioner in chancery of the circuit court of Rockingham County, for several terms a magistrate for the central district of Harrisonburg, died at his home in that city, March 25, from cerebral hemorrhage, aged 78.

Dr. Wm. R. Howard, '79, President of the Alumni Association last year, and one of the most prominent physicians in Rochester, New York, died after a brief illness, on May 22 at the age of 54.

He was a member of the Medical Society of the City of New York, one of the charter members of the Rochester Pathological Society, a member of the staff of St. Mary's Hospital, and surgeon to the Buffalo, Rochester and Pittsburg Railway.

He was born at Periton, January 28, 1855, was educated in the Fairport schools and later in the Geneseo State Normal School, and was graduated in 1877. After that time he took up the study of medicine and after his graduation was assistant resident physician for two years, and resident physician for one year at the Baltimore City Hospital. He began the practice of his profession in Rochester in 1880. In 1885 he was married to Miss Cora Griffin, who survives him together with one son and two daughters.

### Personal Motes.

Dr. J. C. Fiske has been appointed superintendent of the S. R. Smith Infirmary in New York City.

Dr. French Carey, who is now located at El Paso, Texas, where he is interested in a Pasteur Institute, was a visitor in Baltimore in June.

Dr. F. E. Drowne, '04, who is now located at Childsborough in the tide-water country of Virginia, spent a few days about the College in the middle of June.

DR. AND MRS. CHARLES H. HALLIDAY, now living at Fort Fremont, South Carolina, had an addition to their family on March 24, 1910, in the shape of a handsome girl.

- DR. J. G. CALLISON, one of the pathologists in the pathological laboratory in the New York Post-Graduate Medical School and Hospital, is doing research work on the subject of vaccines.
- Dr. T. Jud McBee, of Elkins, West Virginia, has been appointed medical superintendent and will have entire charge of the West Virginia Humanitarian Society State Home for Children.
- Dr. F. C. Schumacher, '05, has been appointed lecturer on materia medica and pharmacology in the Fordham University. He is also medical inspector in the health department, New York City.
- Dr. J. M. Laslie, '03, Montgomery, Ala., was a visitor at the College in the month of June and states that if every one with hook worm in the south had a million dollars it would be a paradise for doctors.
- Dr. Charles G. Miles, city physician to Brockton, is taking great interest in cleaning up the town and started a campaign on the rats. He thinks it would be a good plan to offer a cent a piece for all the rats killed by the boys in the town.
- Dr. J. A. Bailey, '95, of Tyrone, Pennsylvania, has been elected secretary and treasurer of the Tyrone Medical Club. The club is composed of physicians in and about Tyrone and is one of the most progressive of its kind in central Pennsylvania.
- Dr. James M. Finch, '95, spent the month of June in Baltimore following the work at the various clinics at the Mercy Hospital and elsewhere. Dr. Finch is located at Champaign, Illinois, which is celebrated for being the home of the University of Illinois.
- Dr. E. J. Tabet, of Beyrout, Syria, whose interesting letter we publish this month, sent us a copy of the statutes and by-laws of the Society of Physicians and Pharmacists of Syria of which Dr. Tabet had the honor of being one of the organizers.

The official language of the Society is Arabic, but foreigners are permitted to speak in Turkish, French or English. Members residing in Beyrout pay three mejidiehs as an entrance fee in advance and three more as an annual membership fee.

In addition to the by-laws there is a chapter on medical ethics going into detail of the duties of physicians, consultants and the relation the physician, pharmacist and patient.

The medical tariff is interesting. They desire that professors of medical colleges should confine their practice to consultations only, or, in case this be not possible, that their fees should be not less than ten in their office and twenty francs in the patient's house.

Practitioners, not professors in colleges, should not accept as a fee less than half a mejidieh in their office nor less than one mejidieh in the patient's house. It is more fitting that the rates should be double. They also specifically state that physicians should not permit any discount in their bills.

### Correspondence.

REEDY ISLAND QUARANTINE VIA PORT PENN, DEL.,

June 15, 1910.

Dear Emil.—Received the photo. of the boys at the re-union and it certainly is a good picture of every individual. I enjoyed myself so much in meeting the fellows again that I think we ought to have more frequent ones. If I owe anything let me know. Hoping to see you here soon, I remain with best wishes to you and Mrs. Brack, as ever,

Yours sincerely,

CHAS. W. VOGEL.

Buffalo, N. Y., June 19, 1910.

My dear Brack.—The pictures which you forwarded were received a few days ago and are much appreciated. They will be kept as a remembrance of a most enjoyable time. The "Committee" are not only to be congratulated on the success of the affair, but are to be thanked for their painstaking care in behalf of the men of '95.

I have heard nothing of the condition of Dr. Dobbin, and hope that he is recovering satisfactorily. Please give my regards to Mrs. B. and all there in whom I am interested.

Sincerely yours,
EDWIN A. BOWERMAN.

P. S.—I have been chosen to teach hygiene and sanitary medicine in the University of Buffalo for the next year.

BEYROUT, SYRIA, May 15, 1910.

Dear Dr. Brack.—Many thanks for the Alumni Journal which you have sent me. I have already received the October and January numbers. Enclosed please find money order for \$1.00 as my subscription for 1910.

Now a word about the P. & S. and never-to-be-forgotten Baltimore. You have no idea how I feel about the old town, nay, about America in general. Indeed, very few foreigners have ever taken so much liking to the country and to the people as I have. At least, few of them have kept as many good recollections. And how could I feel differently? The country is so great and beautiful and the people are so nice and kind. In truth, one of my great wishes is to visit the birthplace of liberty once more. And who knows but that I may do so some of these days, unless your Mr. Campbell's next move will be to close altogether American shores in the face of us Syrians, who, of all foreigners coming to your land, are perhaps the ones who like you best and admire you the most.

Before I close my letter, I must request you to kindly remember me to Dr. Keirle, Jr., and to give my highest respects to that noble heart, the beloved Prof. Keirle, whose kindness to me I shall never forget. My salams to Dr. Harry Friedenwald.

Yours sincerely,

DR. E. TABET.

P. S.—Under a separate cover, I send you four packets of Turkish cigarettes, two of which please hand over to Dr. Keirle, Jr. I also send you a copy of the statutes and by-laws of our medical society, which, I presume, you will be glad to know I had a hand in bringing into existence. The copy is a translation from Arabic, which is the original.

STAPLETON, N. Y., March 30, 1910.

My dear Brack.—Once again we have a move and this time we go to Reedy Island Quarantine Station in Delaware Bay. Please address me in the future at Reedy Island Quarantine Station via Port Penn, Delaware. Regards to you and Mrs. Brack from Mrs. V. and myself. Remember me to all the boys.

Very sincerely, CHAS. W. VOGEL, '95. ELIZABETH, N. J., June 11, 1910.

Dear Doctor.—Enclosed please find check for Alumni dues. The Journal is certainly interesting, and I wish it every success.

Respectfully yours,

A. W. LAMY, '08.

TAKOMA PARK, D. C., June 14, 1910.

My dear Brack.—Received the photos. of class re-union to-day. Am very glad to have them, they are just splendid. We are certainly indebted to you, McGlannan and some of the other P. & S. men living in Baltimore, for a most delightful time at the re-union. I am certainly pleased that I was able to be with you and truly hope that when the next call is sounded that it will be possible for us all to again look each other over.

With the very best wishes for your happiness. Sincerely,

W. H. WICKLINE.

New York, December 15, 1909.

Dr. Charles F. Bevan, Dean of the College of Physicians and Surgeons, Baltimore, Md.

Dear Sir.—I beg to thank you for your letter with reference to Dr. J. C. Fisk. After careful consideration of numerous applications, we have appointed Dr. Fisk as superintendent of the S. R. Smith Infirmary, and I have great hope that he will prove so competent and efficient as to fully justify your endorsement of him.

With thanks for your interest in the matter, I remain,

Yours very truly,

WILLIAM G. WILLCOX.

New York, April 25, 1910.

My dear Dr. Brack.—Please address my Alumni Journal to me at 601 W. 135th St., New York, N. Y., as that will be my home address for some time. I am testing out the process of ammonia determination I spoke to you about in Baltimore, using Schlessing's method as a control, and find it gives values closely approximating those of the latter method. As the formalin titration is short and requires no apparatus, I think it should be a very valuable addition to clinical laboratory methods. They are now making daily use of the method here in determining the

ammonia output of diabetic patients and others in whom ammonia is a factor. The process is described in the Journal of the American Medical Association for December 18, 1909.

I seem to have stepped into an opening for vaccine work here. There are many cases in the hospital suitable for vaccines, but no one was doing the work here until I came in. I have started vaccine treatments on four patients in the last ten days, besides which there have been five cases of gonorrheal vaginitis in children placed on vaccines since I came here, and they are doing well.

Yours truly,

J. G. CALLISON.

601 W. 135th St., New York, N. Y.

#### THE HAY-FEVER PROBLEM.

Again the physician is called upon to grapple with hay-fever, and a veritable army of sneezing, watery-eyed "miserables" come to him for relief. For a long time the idea was prevalent that little or nothing could be done for these people. The patient dreaded the coming of the disease, and the physician dreaded the coming of the patient. The situation was one of ample misgivings and scanty faith. Now it is pretty well recognized that medication, while still empiric to a certain extent, is nevertheless effective. The symptoms can be controlled or greatly minimized, and the patient may have the relief he seeks. And for this much he will be truly thankful, and the physician, in turn, duly thanked.

Adrenalin is perhaps the most effective agent. It antagonizes the symptoms and secures to the patient a marked degree of comfort. It allays the congestion of the mucous membrane, reduces the swelling of the turbinal tissues, controls the nasal discharge, cuts short the violent paroxysms of sneezing and the abundant lacrimation, and prevents depression by stimulating the heart.

The practitioner who desires to employ Adrenalin in the treatment of hay-fever has recourse to the product in a number of forms. Adrenalin Chloride Solution (1:1000) is doubtless the most widely used. It is first diluted with four to five times its volume of physiological salt solution, then sprayed into the nares and pharynx. Adrenalin Inhalant has many adherents. This is an oil solution, and is administered by spray. It may be diluted with olive oil—the inhalant one part, olive oil three to four parts. A third preparation is Adrenalin Ointment (1:1000), which is effective either alone or in supplementing Solution Adrenalin Chloride. Another is Adrenalin and Chloretone Ointment—at once an astringent, antiseptic and mild anesthetic. The latest is Anesthone Cream (Adrenalin Chloride 1:20,000, para-amido-ethylbenzoate 10 per cent, in a bland oil base), an astringent, anesthetic ointment. The ointments and cream are supplied in collapsible tubes with elongated nozzle, which facilitates their application to the nasal mucosa.

Literature on any or all of the products above mentioned may be had upon application to the manufacturers, Messrs. Parke, Davis & Co., at their general offices in Detroit or any of their numerous branch houses. The company, by the way, issues an attractive brochure on the subject of hay-fever.



In the treatment of vasomotor rhinitis-or hav fever, as the disorder is better known-Adrenalin has proved the most satisfactory agent at the command of the practitioner. While not a specific in the strict sense of the word, it controls the symptoms very effectually and secures for the patient a positive degree of comfort.

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are the preparations most commonly used, being sprayed into the nares and pharynx. The Solution should be diluted with four to five times its volume of physiological salt solution. The Inhalant (preferred by some physicians because of its oily base, which imparts an emollient effect and renders the astringent action more enduring) should be diluted with three to four times its volume of olive oil. Both are effectively administered by means of our Glaseptic Nebulizer.

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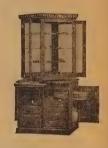
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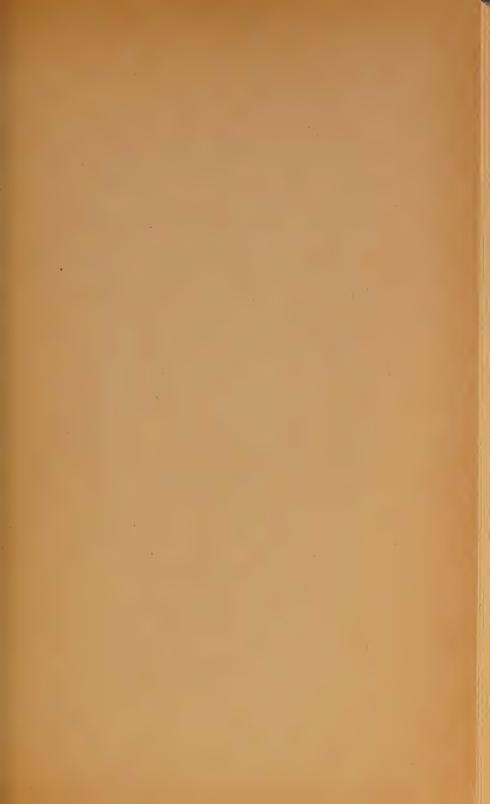
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OF THE

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OF THE

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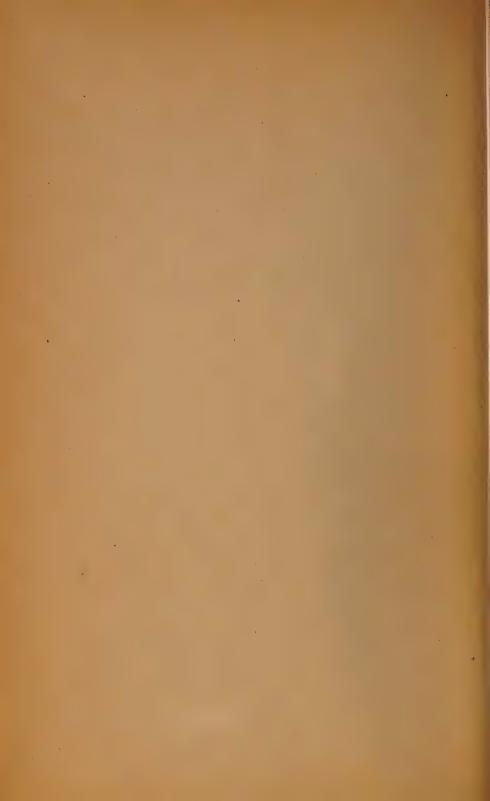
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Vol. XIII

No. 3

OCTOBER, 1910

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# THE JOURNAL

### OF THE ALUMNI ASSOCIATION

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### COLLEGE OF PHYSICIANS AND SURGEONS.

BALTIMORE.

#### IDEALS OF STUDENT LIFE.

By DR. EMIL NOVAK.

Every year the Faculty, in a not unnatural desire to win the favor of the gods, immolates one of its members after this fashion. To all save the unhappy victim who is thus offered up as a sacrifice the custom should appeal as a pleasing one, and one which is worthy of continuation. In response to a recent summons from the powers that be, I have, in a dutiful though self-mistrusting spirit, ventured to assume the pleasant function of extending, on behalf of the Faculty and Adjunct Faculty, a cordial welcome to those of you who are with us for the first time, as well as those whom we have already learned to know. Let it not be thought that this official greeting is an empty and meaningless formality. Even the most blasé among you must realize the significance and importance of an occasion which marks your official entry into the field which you have chosen for your life's work. From your presence in these halls it may be assumed that you are willing to burn all your bridges behind you and to cast your lot, for better or for worse, with the followers of Æsculapius.

The memory of my own emotions on a corresponding occasion in my life is sufficiently fresh to allow me to appreciate fully your own sentiments as you stand to-night at the outermost gateway of medicine. How well I remember the eager anticipation with which we awaited the first developments of our medical career, and how strong is the recollection of that shrinking timidity and strange half-fear with which our eagerness was tempered! How avidly we drank in every word of the introductory address, and how tenderly we pieced together the fragments of broken

English in which this particular address was delivered! Every year since then it has been my privilege to listen to an introductory address delivered on an occasion of this sort, though not always, it must be confessed, with that unsophisticated enjoyment which only the first could excite.

In selecting a subject for discussion on an occasion of this kind one need never be embarrassed by a scarcity of eligibles. The possibilities for embarrassment lie at the other extreme. Nothing could be more interesting, for example, than an excursion into the history of medicine, to many of us still a "terra incognita." Much inspiration could be drawn from the study of any of the great men or the great events in the history of our profession, or, perhaps, from a panoramic review of the science as a whole. On the other hand, one might be tempted to devote an address of this kind to the consideration of some especially interesting topic along purely scientific lines. It has seemed to me, however, that a paper of either of these two types would scarcely fulfil all the requirements of such an occasion as this—an occasion consecrated to the neophytes of our entering class. It would be difficult to prepare a medical paper along either historical or scientific lines which would be fully within the range of appreciation of those whose ear-drums have not as yet learned to vibrate to the ponderous polysyllables of our medical terminology. I have therefore felt that a wiser and more humane plan would be to speak simply and directly, out of the fulness of my heart, upon various and sundry matters which, if my memory serves me correctly, were of deep interest to me at a corresponding period of my own career.

A great deal, much more than you can now realize, depends on getting started properly, for as a man directs his course in his first year he is quite apt to continue in the succeeding ones. At the end of the first term it will not be difficult to pick out the men who will stand at the head of the class on your commencement day. It has for this reason always seemed to me that the instructors upon whom the greatest responsibility rests are those who are brought into contact with the freshman class, for it is in his first year that the medical student is most susceptible to the moulding process, and a strong personal influence on the part of the right sort of teacher may be the destiny which shapes the ends of the future physician. Many of you, who come to the city from other and usually smaller towns, are quite likely to flutter about somewhat aimlessly until you get your bear-

ings and finally come to rest. This is a danger period, for unless you soon anchor your frail bark very securely, you may ere long be drifting help-lessly away from the island of success. The latter always lies upstream, and the swift current is sure to carry the mere drifter farther and farther away from its verdant shores.

At the very outset let me impress upon you that the study of medicine is anything but a bed of roses. Remarkable as have been the advances made in the last century or so in the science of medicine, they are less revolutionary than the transformation which has come over the teaching of medicine. During the greater portion of the eighteenth century no preliminary education whatsoever was demanded of the lad who aspired to the study of "physic." At an early age he was bound out as an apprentice to some physician or surgeon of the vicinity, for a period of from three to seven years. For the first few years the services performed by the apprentice were of the most menial character, while both the quality and quantity of medical learning he obtained from his preceptor depended upon the ability and temperament of the latter. The following extracts from an agreement made between preceptor and apprentice in the year 1760 will give some idea of the relations existing between the two: "During which term" (four years and eight months) "the said Apprentice his said master well and faithfully shall serve, his secrets keep, his lawful commands everywhere obey. He shall do no damage to his said Master, nor see it be done by others without letting or giving notice to said Master. He shall not contract matrimony within the said term. At cards, dice or any other unlawful game he shall not play, whereby his said Master may have Damage. He shall not absent himself day or night from his said Master's service without his leave, nor haunt Ale houses, Taverns or play houses, but in all things as a faithful Apprentice he shall behave himself toward his said Master all during his said term. And the Said Master during the S'd term shall by the best of his Means or Methods Arts and Mysterys of a Physician and Surgeon as he now professes Teach or cause the said Apprentice to be Taught to perfection in the consideration of the sum of One Hundred Pounds Lawful money of New York to him in hand paid by the said James Hubbard (in four payments) that is to say Thirty Pounds in hand down, and the remainder in Four Equal payments, One each year till the whole is paid, And the said William

Clark Acknowledges himself therewith contented and the receipt thereof. And the said Master is to provide his said Apprentice with sufficient Meat, Drink, Washing and Lodging and Mending his said clothes during the Said term. And the said James Hubbard is to find him in wearing apparel during said term aforesaid. At the end of Said term the Said Master shall and will give unto the said Apprentice a new set of surgeon's pocket instruments—Solomans Dispensatory, Quences Dispensatory and Fuller on Fevers," etc. As the apprentice drove about the countryside with his preceptor he was instructed in the rudiments of anatomy and physiology, and likewise taught to recognize the signs of disease. The master was an entire medical Faculty in himself—he represented the undifferentiated protoplasm of medical education.

How different are the conditions surrounding the teaching of medicine at the present day! Both in its practice and in its teaching the modern process of specialization has cut up the field of medicine to what many believe is a dangerous degree, and anatomy, physiology, pathology, internal medicine, surgery, obstetrics-each is a science in itself. While such division of labor tends toward scientific concentration, it is quite apt to engender a dangerous narrowness. During your student days at least you will, fortunately, be protected from too great partiality to any one branch by the unsentimental requirements of the college curriculum. At any rate I trust that you do not come here with your specialty already picked out, as I have more than once known to be the case. One of the most common faults of the young medical student is a too distant anticipation of the actualities of the professional life which he may perhaps never reach. As long as this expectant frame of mind confines itself to experimentation with various types of beard, or to frequent visits to the undertaker for the purpose of cultivating a "grave" demeanor, there is more of humor than of tragedy in it. But when this hypermetropic type of student neglects to prepare his quiz in anatomy or physiology because he has been shopping for medicine cases and instruments of which he has not as yet learned the use or perhaps the name, the humor vanishes and the tragedy rules triumphant. Is it heartless to tell such a man that his medicine case will perhaps be the only case he will have during the first few months of his practice? Knowing his itchy nature it would probably not be far wrong to tell him that the instrument case will certainly be his most dangerous one for some time after he precipitates himself upon a community.

It is human nature, I know, to anticipate both good and evil. And yet this anticipatory frame of mind is the cause of much needless unhappiness and mental anxiety, while at the same time it is a powerful inhibitor of really useful work. How frequently do we see students worrying from day to day about the ordeals of the morrow, while at the same time there constantly looms before them, like a motionless black cloud on the horizon, the torturing doubt of ultimate success in their chosen work. At the outset of your student career you can learn no more important rule than this: Think not of the ordeals of to-morrow until to-morrow becomes to-day. It may seem like a short-sighted policy to set for yourself, but there is no better way of ensuring your future success than by "nailing down" the present. To use a rather opposite comparison, the man who, in the race of life, is continually looking back to see how far ahead of his opponents he is, will, other things being equal, have little chance to win against the one who grits his teeth and, without thought of anything else, opens wide the throttle of his energies and dashes on toward the finishing line. This same thought is expressed by Carlyle in his more elegant diction thus: "Our duty is not to see what lies dimly at a distance, but to do what lies clearly at hand."

The past is gone, and we can reach it only by the bridge of memory. The future is not yet ours, and we can influence it only indirectly and without certainty through the present. But the present is ours, and we can do with it as we like. You can make no better investment than to throw all your energies and vital resources into the present, for at life's compound interest they will be returned to you manifold, and you will some day be surprised at the extent of your personal resources. A man's position in the world is the result of a most intricate mathematical process which continues throughout his life, and which involves all aspects of his human activity—physical, mental, moral, social, financial, etc. Few there are who are not spendthrifts of their natural assets, though some are greater squanderers than others. In the present-day agitation of the question of conservation of natural resources, have we not overlooked the equally great importance of conservation of personal resources?

In thus urging upon you the importance of living in the present do not

for a moment think that I am calling upon you to lay aside all ambition and worthy aspiration. Nothing could be farther from my intention. Honorable ambition is never a crime; the lack of it is always reprehensible. But mere anticipation, the mere indulgence in idle day-dreams, is not ambition. As the Roman eulogist emphasized, "Ambition should be made of sterner stuff." It has always seemed to me that there are two principal types of ambition—a true and a false, or, if you choose, a working ambition and a dreaming ambition. The latter type often deludes its poor victim, and not infrequently his friends, into the most unwarranted expectations of future glory. I have myself been thus deluded, by my friends, perhaps also by myself. I well remember one of my classmates, who was also a member of the same hospital staff as I, a jovial and lovable fellow, who could sit for hours in a comfortable chair, with feet high in air, and work himself into a fine frenzy of poetic imagination concerning his future life, who could draw from his cigarette the most roseate dreams of the greatness which lay in store for him. All this, however, while he was neglecting the work of the present—while the histories of his patients were unwritten, while his laboratory work was neglected, and while physical examinations were passed by as entirely too irksome. From his speech, or as some would say, from his ambition, one might say that a great future lay before him. As yet, however, the world has not heard from him, and knowing the disparity between his dreams and his actual accomplishments, I would not fear to predict that his name will never be found in the hall of fame.

I remember reading somewhere, away back in the days of my childhood, a fable of the Arabian street merchant who, discontent with his lot in life, spent much time in longing for riches and affluence. One day, instead of busying himself in selling his wares, he fell asleep in the market-place, with his basket by his side, and dreamed that he was a rich man, with slaves groveling in the dust at his feet. Remembering his own former fancied wrongs, he proceeded to kick the slaves away, and with such unfortunate realism that he overturned the basket at his feet, demolishing all its costly wares. His day-dream was an expensive one, as day-dreams frequently are. Not that there is anything innately wrong in allowing the fancy to roam into the future, in the pleasing diversion of building castles in the air. The danger is of a negative rather than a positive type.

In itself the sport is a harmless one in which we all to some extent indulge, especially in the haloyon days of youth. It is to youth what blowing soap bubbles is to childhood. With most of us the beautiful airy castles which we build for ourselves remain ever unreal—they never pass beyond the nebular stage of their existence. Under the magic formative influence of the right sort of ambition, however, these ethereal castles can be made to take on the shape and substance of actual reality.

The second type of ambition I have spoken of as the true or working type. The higher one sets his aim in life, the greater the effort required to reach it. The lazy man is content to view it at a distance, but the truly ambitious one does not spend his time in sighing like a bellows for the object of his heart's desire. He takes up his burden with determination and carries it with persistence over obstacle after obstacle until he has reached the top of the mountain of success. Some who reach the top do so only after a slow and laborious climb, made successful only by the exercise of that "bulldog tenacity" which will counterbalance a multitude of shortcomings. Others again, with native ability of a high order, push forward at a brisk rate and soon have planted their banner at the top. Look about you at the men who have made a success of life-in medicine, business, literature, or what not. The tendency of the world is to speak of every successful man—using the word successful in its nobler sense—as a genius. Many a man is thus misbranded. Genius has been defined, and correctly, I believe, as an infinite capacity for taking pains, or in other words, an infinite capacity for hard work. The man who is wrongfully accused of being a genius is most frequently one who has made the fullest use of his original capital in life—who has invested it to the best advantage and who is now a rich man as far as personal resources go. By calling such a man a genius society complacently offers a sop to the shortcomings of most of its members, many of whom have squandered an original capital perhaps much greater than that of the so-called "genius." As you proceed in the study of medicine, some of you will pull away from the main body of the class, and when the final horn blows will be proclaimed the leaders. There will be a tendency on the part of some of their comrades, and perhaps also of some of the instructors, to speak of them as exceptionally gifted, and to tell wonderful stories of the ease with which they mastered the various studies of the curriculum. With a qualification

which I shall presently draw, this attitude is usually incorrect, and does injustice to the men concerned. They have much justification for a feeling of irritation that their success is not ascribed to any effort of their own, but rather to the munificence of their forebears, who bequeathed to them certain mental characteristics which enabled them to tower far above their fellows.

Here let me protect myself from criticism by assuring you that I have no wish to convey the impression that, as far as natural abilities are concerned, all men are born equal. Such a view is too palpably wrong and absurd for serious consideration. The medical man who would deny the influence of heredity in determining mental characteristics would indeed be setting himself against all the traditions and all the present knowledge of his profession. The mind, infinitely more subtle than the body, permits of far more delicate shadings of variation, and, if individuals present countless physical variations, how much greater are the possibilities of difference in mental capability. But this does not alter the burden of my argument, and again I would insist that without hard work real success is impossible, and that even without any overpowering native ability, there are few to whom honest and patient endeavor will not bring a fair measure of success. It is those rare instances where there is a conjunction of such persevering industry with natural ability which punctuate the narrative of history with the lives of men who tower far above their fellows-men whose greatness, like that of the true poets, is partly inborn and partly acquired.

You will observe that I am laying much stress upon the importance of work in your student life. If you forget everything else which I have said or shall say, I would urge you to take away with you that one word, work—the master-word in medicine, as one who is himself a master-mind in medicine has called it. As Osler has said, "Though a little one, the master-word looms large in meaning. It is the open sesame to every portal, the great equalizer in the world, the true philosopher's stone, which transmutes all the base metal of humanity into gold. The stupid man among you it will make bright, the bright man brilliant, the brilliant student steady. With the magic word in your heart all things are possible, and without it all study is vanity and vexation. The miracles of life are with it; the blind see by touch, the deaf hear with eyes, the dumb

speak with fingers. To the youth it brings hope; to the middle-aged, confidence; to the aged, repose."

Look back over the history of our own profession. From the countless array of advances and discoveries which are distributed throughout the centuries, how many can you pick which were not made possible by work, often by work alone? Do you think that Harvey's discovery of the circulation was a happy idea that dawned upon the pupil of Fabricius overnight? Not so, for it was only after the most prolonged investigations upon both warm- and cold-blooded animals that he finally arrived at the truth. Not only work, but also that bulldog tenacity of which I have already spoken characterized Harvey's investigation, for he was compelled to maintain the truth of his observations in the face of the ridicule of the entire profession of his time, many of whom considered him actually demented for holding such revolutionary ideas. Read the history of vaccination, of antisepsis, of anæsthesia, of any of the monuments which master-minds have erected for themselves in the field of medicine, and the cornerstone of each monument is work. Occasionally, it is true, discoveries of real importance have been made through pure accident, but in the great majority of cases such accidents have occurred during somebody's work. Sometimes, again, great truths have been arrived at by the sudden sally of some brilliant intellect, guided by the bounteous hand of Providence, but far more frequently advances in medicine are the result of slow and painstaking labor, frequently on the part of many men in many lands.

As a concrete example of what seems to me to be a model of patient scientific work carried out for the welfare of humanity, let me cite one more instance. One morning in the June of 1822, a young French Canadian voyageur, Alexis St. Martin by name, was shot in the abdomen by the accidental discharge of a companion's shotgun. The shooting occurred at Fort Mackinac, a small post whose inhabitants carried on a fur trade with the Indians. After the shooting St. Martin was attended by Dr. Beaumont, the surgeon of the fort. Although his life was despaired of, the patient surprised his physician by recovering, though very slowly. The site of the wound, however, was marked by a permanent fistula into the stomach. In view of the fact that the man was in destitute circumstances, and, we cannot help believing, for somewhat ulterior though highly laudable scientific motives as well, Beaumont took St. Martin into his

family, "for the special purpose," he said, "of making physiological experiments." Those experiments, commencing in May of 1825, continued for fully eight years, often under most trying circumstances. Though ordered about from post to post, the surgeon always carried his human physiological laboratory with him, hanging on like the grim death from which the patient had so narrowly escaped. All during this time he was carrying on that series of brilliant experiments, 238 in all, which form the basis of our modern knowledge of gastric physiology, and to which, indeed, subsequent generations have been able to add comparatively little of real importance. That the physiology of the stomach was very imperfectly understood may be inferred from the sarcastic remark attributed to William Hunter that "some physiologists will have it, that the stomach is a mill, others, that it is a fermenting vat, others, again, that it is a stewpan; but, in my view of the matter, it is neither a mill, a fermenting vat, nor a stewpan; but a stomach, gentlemen, a stomach." Among the results of this remarkable work of Beaumont were an accurate knowledge of the composition of the gastric juice, the recognition of hydrochloric acid as the important acid of that fluid, a study of the digestibility of different articles of diet, the first intelligent study of the movements of the stomach, etc. The work—and it was work—of this back-woods physiologist will ever remain a model of patient and diligent investigation, rendered no less scientific by the fact that it was carried on in the wilderness rather than within the four walls of a well-equipped laboratory.

Now then, ask yourself what you would have done if confronted with an opportunity such as this. Would you, or would I, as a matter of fact, have even recognized it as an opportunity, or if we had, would we have put it to such golden use as did Beaumont? An old saying, much quoted, is that "Opportunity knocks but once at a man's door." To my mind, no more fallacious sentence was ever framed. Do not let it secure a foothold in your heart. The men who do not have innumerable opportunities are like those old practitioners of medicine who have never encountered lacerations of the perineum in their obstetric practice, or those who have never seen a case of ectopic gestation. In the first instance, the lacerations are not seen because they are not looked for, and in the second, the ectopic pregnancy is not encountered because it is not recognized. So it is with opportunity. Some there are who never have opportunities because they

never seek them, while others would not recognize an opportunity if directly confronted with one. We are told that God helps them who help themselves. In other words, the right sort of man can make his own opportunities as he goes along, to fit each individual need that may arise. Some of you will recall the story of the old darky who felt much in need of a turkey for his Christmas dinner. Two nights in succession he had dropped to his knees and called upon the Lord to send him a turkey, but in vain. On the third night, however, he changed the nature of his prayer somewhat, calling upon the Lord as follows: "O Lawd, please send dis coon a turkey, and O Lawd, please make dis coon go and get dat turkey!" Needless to say, this time he got his wish.

Let me next urge upon you the cultivation of another attribute almost as essential to your success as work itself. Why is it that all students who work hard do not succeed? We may of course eliminate from our consideration that small proportion of every class who are doomed from the very outset, either from congenital over-thickness of the skull or from certain acquired characteristics which make them absolutely hopeless. Let us confine our attention to the hopeful cases, those with normal brain development and normal capacity for hard work, who nevertheless achieve no higher distinction than that of "average student." In the majority of cases I believe that the failure to attain the position to which their hard work entitles them is due to one thing-lack of system. It is this failing which is to blame for the immense waste and misdirection of brain energy which, to my mind, constitute one of the tragedies of student life. Lack of system is commonly excused in that "rara avis," the real genius, and it may be that there are a few brilliant intellects which are able to dispense with it altogether. But with most of us, hard work without system is quantity without quality, and quantity without quality usually spells mediocrity.

What has been said of system applies also to the quality of thoroughness, and, indeed, it is rare that the systematic mind lacks thoroughness—that ability to reach the very heart of a matter. The mere acquisition of a mass of facts will not make you wise; to be of lasting value they must be incorporated into your very life. As Tennyson remarks, "Knowledge comes, but wisdom lingers." In other words, knowledge becomes wisdom only after being thoroughly "Fletcherized," digested, absorbed, and assim-

ilated into your mental beings, and unless all these various processes are carried out thoroughly, you will soon become a victim of that form of indigestion which shows itself by emaciation of the mind, loss of ambition, and other common symptoms. Neither system nor thoroughness grow like wild flowers in the cerebral gardens of the ordinary medical student. Both must be carefully cultivated, but when once they reach their full bloom, both are things of beauty and joys forever. It is superficiality, which is merely lack of thoroughness, that is to blame for the prevalence of certain vicious tendencies in the medical profession of all ages, such, for example, as the all too common fault of self-deception and wilful misunderstanding. In former days this was much more conspicuous than at present, as would seem to be well illustrated by the ancient Egyptian belief, quoted by old Stephen of Athens in his treatise "On the Signs of Virginity," that "a reliable diagnostic sign of virginity may be found in the fact that peas upon which a virgin has urinated, germinate, while the contrary condition of sexual purity may be proven by the failure of the peas to sprout—apparently a very accommodating doctrine when we consider the germinative power of peas!" (Baas).

Having been so generous with my advice as to what you should do and how you should do it, I may be allowed a word as to a few things which it were better for you to avoid. Do not forget, first of all, that you are not beginning a mere academic or college course, but that to-day you enter upon your life course—to-day, I say, and not four years hence, as you might believe. It will be a little hard for many of you, especially those of tender years, to wean yourselves abruptly away from the things of childhood, and yet this is clearly your duty. The fact that some are unequal to the task is shown, for example, by the survival of the ancient and senseless custom of hazing, a relic of bygone ages. That conditions at the present time are at any rate no worse than in the days of old would seem to be attested by the following description, from Grün, of the ordeals of the poor freshman in mediæval days: "Disgusting drinks, composed of phlegm, ink, vile stinking butter and candle stuffs, were given to him to drink, and he was initiated by cuffs and kicks into the honorable position of an academic citizen." Or, listen to this description of class behavior at that period: "Scarcely a public lecture was delivered anywhere without insolent and unstinted interruptions by hissing, whistling, and abominable noises. There was such a bellowing, shouting and howling that a passer-by would swear that it was no lecture room for men, but a resort for dogs, oxen, and birds of prey." What a delightful picture of your progenitor! How fortunate that we are able to say, "tempora mutantur!" On the whole, the American student of the present day compares very favorably with his brother in other lands, especially Germany, where the free and easy spirit of university life is still shown by the prevalence of brawling, duelling, and other studious pursuits.

Of such common vices as drinking and gambling I do not propose to speak, except to say that their influence, always baneful and frequently ruinous, is more strongly felt in medicine than in almost any other vocation in life. Of that other black vice, always blackest when it grips a physician—immorality—I shall say nothing except that he who worships at the shrine of Venus may also make the acquaintance of Mercury, an even harder customer to get rid of than the "Old Man of the Sea." Your ultimate success in life depends more upon the man in you than upon the doctor in you, and anything that undermines your manhood and strength of character lessens your chance of putting up a winning fight.

Four years hence this class will be poured into the veins of our profession. That much depends upon the preparation of this infusion everyone must realize. If the preparation be unskillful, the infusion will excite an annoying and harmful reaction in the body of the profession. But if the process be as thorough and successful as the past history of this institution leads me to believe it will be, your entry into the profession will not only be devoid of any harmful effect, but it will actually carry with it the life, warmth, and energy which youth alone can supply.

In the course of these rambling remarks I fear that I may have assumed toward you a paternal attitude to which neither abundance of years nor abundance of wisdom entitles me. But I have tried to speak to you as a young man to young men, and I have therefore aimed to make my address inspirational rather than educational. In the decade which has elapsed since I entered upon my own novitiate in medicine I have seen enough of its charms and trials to be able to assure you that you have selected for your life work the most fascinating and at the same time the most responsible of all professions. In spite of the constant cry of overcrowding, there is in medicine, as in all other walks of life, urgent need of the right

kind of men, especially young men. As our great American poet-physician said, "New ideas build their nests in young men's brains" and "The first whisperings of truth are not caught by those who begin to feel the need of an ear-trumpet."

For, after all, your future life will be, or at any rate should be, a neverending quest for truth. There is an old Egyptian legend to the effect that the goddess of truth, Osiris, was assassinated by a band of conspirators and her body divided into a thousand pieces, which were scattered to the winds. Ever since that time mankind has been searching for the missing fragments of truth. Some of you, more successful than others, may come upon many of the precious bits, though your search will be a laborious one and may lead you far afield from the customary brain paths of your fellow men. It may even be, and let us hope so, that in your ranks some future Koch or Lister is even now impatiently tugging away at the bit. But however far you may roam in your search after the truth, let me urge upon you never to sever those tender ties which your Alma Mater is already commencing to weave about you. In an account of the rules and regulations of an old German university for the year 1588 I came upon an interesting oath of allegiance which all applicants for the study of medicine were required to take. Though I do not like to end my discourse with an oath, let me, as a final thought, commend to you the spirit of this ancient form, which reads as follows: "I swear to you, the Dean of the Medical Faculty, and to both Professors, as well as to the other Doctors of the Faculty, obedience and reverence in everything honorable and allowable; that I will keep all the present and future statutes of this Alma, and wherever I go I will keep in view her best interests. So may God and his Evangels be gracious to me."

#### EXOPHTHALMIC GOITRE.

BY DR. J. A. GUTHRIE, HUNTINGTON, W. VA.

Recognized by Perry in 1825, by Graves 1835, by Basedow 1840. Exophthalmic goitre is a malady characterized by protrusion of the eyeball, palpitation of the heart, rapid pulse, and a fine tremor of hands, arms and head. One in one thousand patients admitted to general hospitals suffers from this disease. It occurs six times as often in women as men, usually from sixteen to forty years of age. Etiology is obscure. It may

follow rheumatism or tonsillitis. The symptoms are due to a pathological secretion of the thyroid gland. Some suggest the possibility of an excessive stimulation of the sympathetic ganglion.

Pathology.—The gland is not usually as large as in simple goitre. The veins and arteries of thyroid are dilated and tortuous, giving a thrill to touch and a distinct murmur on auscultation. The heart may be normal or in a dilated condition, with relaxed spincter of the mitral valve. The parenchyma of the gland is usually increased, there may be a desquamation of the epithelial cells with an overgrowth of connective tissue. Microscopically, there may be no change whatsoever.

Cardinal Symptoms.—Large thyroid gland, exophthalmos, tachycardia, thrill.

The enlarged thyroid gland is obvious and does not need any discussion. Exophthalmos or protrusion of the eyeball is due to the increased fat in orbit, and usually occurs bilaterally.

Von Graefe's sign.—Patient looking towards the floor, the upper lid does not travel downward as rapidly as normal.

Stellwag's sign consists in a widening of the palpebral fissure, with retraction of the lids, showing the white sclerotic coat above and below the cornea of the eye. In pronounced cases the eyelids do not protect the eyes sufficiently, resulting in ulceration of the sclerotic coat. Convergence is often interfered with; vision is not usually impaired, but the patient often complains of pain and throbbing of the eyeball.

Tachycardia.—The pulse varies from 90 to 150, increased on exertion or excitement. Usually the rapidity of the pulse and the palpitation of the heart are the only abnormal conditions. Occasionally one finds a dilated heart, with mitral insufficiency.

Tremor.—A fine tremor, called railroad tremor, may be felt by placing the tips of the fingers against those of the patient. There is excessive nervousness, a slight noise may excite the patient almost to a stage of collapse. Feebleness and melancholia are usually present.

Dyspnæa is a marked symptom; patient is unable to go upstairs, may have to sit up in bed, with plenty of fresh air. Deaths from dyspnæa have been reported. Excessive and obstinate vomiting may complicate the case, and is considered a grave symptom. Diarrhæa may occur occasionally; the skin often shows pigmentation.

Physiological Chemistry of the Thyroid Gland.—Physiological activity of the gland is due to iodine compounds. It is not known whether the iodine must be in proteid combination to exert its full physiological activity, or whether some cleavage product is equally active, or whether there is more than one iodine proteid in the gland. The secretion enters the blood or lymph without the intervention of digestion; on this account, and for this reason, serum is given hypodermically.

TREATMENT.—Medical.—Forchheimer recommends quinine hydromate grs. five, ergot gr. one. He reports forty cases with five failures. He gives this treatment until all symptoms disappear. In case of recurrence the treatment is again instituted.

Surgical.—Surgical treatment is indicated when the gland is large enough to cause pressure symptoms, when the patient grows rapidly worse, with loss of weight, constant fever, or excessive tachycardia. A part or all of the gland may be removed. Contra-indications are cardiac complications, or a lowered physical condition.

Serum Treatment.—The object of this paper is to call your attention to the serum made at the Cornell Research Laboratory, under the direction of Dr. S. P. Beebe. The serum comes in small hermetically sealed tubes, containing about twenty minims. Dr. Beebe recommends this serum to be given hypodermically in the posterior surface of the arm, preferably given in the morning, and the patient required to stay in bed that day. A slight reaction occurs, as a swelling of the arm, urticaria.

Types Favorable to Serum Treatment.—Typical exophthalmic goitres, early stages, mild or severe, incipient forms which develop rapidly, types in which goitre has existed some time, in subacute stages and occasional exacerbations. Types that require combined treatment, cases that develop after fifty years of age. Those cases that have borne goitre for years and late in life develop thyroidism. Atypical cases. By combined treatment we administer both anti-serum and thyroid-proteids. A combined treatment is also used in cases which show a violent reaction from the serum, say one-fiftieth of a gr. of thyroid-proteid, three doses per day, and five minims of the serum.

HISTORY OF CASES.—Case 1, June, 1907, Miss N., age 35, trained nurse, had general breakdown from overwork. Pulse 140, regular, excessive palpitation could be felt over the entire body, unable to sleep, constipation, loss of appetite, irritable. Applied ice bag to the heart, used all known remedies, both

stimulants and depressants, with no results. Removed the patient to the hospital, required absolute quiet. Patient remained in the hospital for three weeks, with no results. Returned home, and after a time took osteopathic treatment. Later she went to Charleston, where she was under the care of Dr. Thomas. From there she went to Richmond, Va. For a month the doctors there sent her to Dr. Thayer, Hopkins hospital, where a diagnosis of exophthalmic goitre was made. Here I feel justified in saying that the protrusion of the eye-ball, and the enlargement of the thyroid gland had begun to develop. The thyroid gland developed gradually, but did not reach a great size. The exophthalmos became marked. She returned home, was given the serum treatment by Dr. C. T. Taylor. One-half tube was given twice a week until 24 treatments were given. There was steady improvement and the symptoms gradually subsided, and the patient was able to resume her work in about three months. There is still some enlargement of the thyroid gland, and the protrusion of the eyes is still noticeable.

Case 2.—February, 1908. Mrs. K., age 37, married, has two children, the youngest eight years of age. Had a miscarriage three months previous to the attack.

Symptoms.—Nausea in the morning, loss of appetite, dyspnea increased rapidly and patient struggled for breath. Extremely nervous and irritable, pulse increased rapidly, hard and wiry, ranging from 100, gradually increasing to 150. Periods of diarrhea, rapid loss of strength and weight. Slight swelling of thyroid, wild, anxious facial expression. Feeling of impending Would see no specialist or allow serum to be used until all known remedies were exhausted. There were some periods during which the patient seemed to improve, but in reality she grew gradually worse, until about June 25, when the serum treatment was instituted. At this time there was a slight exophthalmos and a noticeable enlargement of the thyroid. One-half tube of serum was given every second morning. Quite a little reaction developed, the arm swelling to the elbow. After four treatments were given improvement was marked. Dyspnea and tachycardia were gradually relieved and the patient became comfortable. Treatment was gradually reduced to twice a week, and one tube was given to each treatment. Patient pronounced well at the end of three months. No recurrence to date.

A possible sequela is that the menstrual period never became normal; it is irregular about every third month, scanty, no pain; possibly menopause is near.

Case 3 (Dr. Baker and Dr. McNeal).—Mr. H., age 20, grocer, has had slight enlargement of thyroid gland, with some distension of the right eye, four months previous to an attack of pneumonia. March, 1909, developed an attack of double pneumonia, which lasted two weeks. During convalescence patient developed severe headache, followed by delirium (maniacal), sick stomach, temperature remained normal, gland gradually enlarged and exophthalmos increased. Pulse 120, tremor of muscles. Treatment began April 3, one tube every second day. No improvement until five treatments were given, when delirium was relieved. Gland began to reduce in size and exophthalmos to disappear. About the seventeenth day of treatment the patient had a slight relapse, which lasted about five days. All symptoms at present date have disappeared, except rapid pulse, which remains at 100. Has had about twenty treatments; patient is improving rapidly and is on the road to recovery.

Prognosis of Exophthalmic Goitre.—It is hard to give a percentage of deaths or recoveries. The past three years show only a death rate of 10 per cent from serum treatment. A large number are still under treatment or are under observation of the physicians in charge. Expectation of life after the onset is estimated to be not more than ten years. Best results are found in severe and acute cases.

Material for this paper has been obtained through the kindness of S. P. Beebe.

Dear Doctor Brack.—It rather strikes me that each and every alumnus of our college is falling short of a duty he owes to his Alma Mater and his fellow collegians when he fails to write an occasional letter in our organ of the Alumni Association. It is our sole medium by which we learn of our past comrades.

How often while sitting in an office, perhaps brooding over cases, a slump in business or with nothing to do, do our thoughts wander back to those carefree, palmy old college days, and we indulge in a pleasant revery, speculating on what Tom or Bobby is doing and where.

Just then perhaps the mail man brings the ever-welcome Journal, but seldom do we learn about those we are most interested in. So, fellows, let us brace up and make our Journal a newsy one. We are not all writers of flowery language, but simple words convey what is most appreciated.

As for myself, after finishing my hospital service as senior resident in a northern hospital, I was fortunate in getting well located, just fell into it, and am doing all I anticipated in those dreamy school days. I am doing general surgery, and operate at two hospitals. I will stop at that as I detest a "blower," but will merely add that last month I forsook the ranks of my brother bachelors, and am now an old married man, as is also my old pal, Dr. W. E. Griffith, he having beaten me by a couple of weeks. He is also doing splendidly.

Enclosed please find my subscription. With best of good wishes to all,
I am Fraternally yours,

E. W. Cross, '08.

CURTISVILLE, PA.

WILLIAM S. GARDNER, M. D., EDITOR, 6 W. Preston Street.

JOHN RUHRÄH, M. D., Associate Editor 839 N. Eutaw Street.

CHAS. EMIL BRACK, M. D., BUSINESS MANAGER, 500 E. Twentieth St.

### THE JOURNAL

### OF THE ALUMNI ASSOCIATION

OF THE

# COLLEGE OF PHYSICIANS AND SURGEONS, BALTIMORE.

#### CORRESPONDENCE NUMBER.

This number of the JOURNAL might properly be called the correspondence number, owing to the large number of letters which we have printed. It will be noted that the most popular features of the Journal are the personal notes and the correspondence, and we particularly wish to urge all the alumni to send us letters regarding their welfare particularly as to their appointments to honors of any kind, or news of their participating in any unusual events. We are always grateful for newspaper clippings concerning anything which pertains to any alumnus. If one considers that a letter published in the JOURNAL is like a personal letter to every member of the class to which the writer belongs we should have more frequent and more interesting letters to print. We get frequent requests to publish news items concerning various members, or to locate various members of various classes, all of which indicates an active interest on the part of the alumni in their fellow practitioners. We, therefore, urge again that each alumnus feel that he is particularly bound to make the correspondence columns among the most interesting of the Journal, and if they are not as interesting as he thinks they should be it is his own fault.

#### REUNION OF CLASS OF '96.

Shall we have a class reunion of '96? If so, the initial steps in perfecting plans must soon be undertaken. However, before inaugurating this movement, it would be well to have an expression of the sentiment of the members of the class. The undersigned are ready to serve as a local

committee, and a letter addressed to Dr. H. G. Beck, 214 E. Preston St., or Dr. A. W. MacDonald, 1540 N. Broadway, announcing your desire for such a reunion will lend inspiration and support to the movement, and will help to insure its success. One of the greatest alumni events in recent years was the reunion of the class of '95 at the last commencement when they celebrated their 15th anniversary as doctors of medicine.

The next commencement will represent our 15th anniversary. Let us endeavor to show the class of '95 that there is another class which added lustre and fame to their Alma Mater, and that there exists the same cordial spirit and good fellowship among us which characterizes their class.

A. W. MACDONALD,
ALBERTUS COTTON,
H. C. KNAPP,
JESSE COGGINS,
G. C. THIEME,
WM. WOLF,
H. G. BECK.

#### CLASS REUNIONS.

Those of our alumni, who contemplate having a class reunion are advised to begin agitation; the selection of a working committee, preferably located in Baltimore, should be made now and a canvass of the class made early.

1891, 1896, and 1901 could celebrate respectively their 20th, 15th, and 10th anniversary, and, by combining forces, arrange a most delightful reunion to be held at the time of the commencement in June.

Of the class of '92 there are located in Baltimore: Dr. Melvin Rosenthal, Dr. J. P. Wade, Dr. Chas. R. Shoemaker, Dr. Jos. Roach.

Of '96: H. G. Beck, Jesse Coggins, Albertus Cotton, H. C. Knapp, A. W. MacDonald, G. C. Thieme, Wm. Wolf.

Of '01: Lewis J. Rosenthal, Samuel Schmidt, Jno. J. Stiefel, M. T. Sudler, Samuel Weinberg.

Alumni contemplating taking part in the reunions will confer a favor by communicating with their respective representative or with Dr. Chas. E. Brack, so that we can determine early whether there is sufficient interest manifested to justify the committees making the necessary arrangements.

#### CHANGES IN THE FACULTY.

Among the recent additions to the Faculty are the following:

Dr. Charles E. Simon, formerly of the Baltimore Medical College, and the well-known author of a very popular book on clinical diagnosis, has been appointed Professor of Clinical Pathology and Experimental Medicine.

A new clinical laboratory has been fitted up on the second floor of the College building, and the course given by Dr. Simon will be thorough and up-to-date in every detail. Dr. Simon will also hold a fortnightly seminary for the study of problems connected with diagnosis and experimental medicine. He will be assisted by Dr. W. Milton Lewis, formerly Professor of Bacteriology and Pathology in the Woman's Medical College. He will be also assisted by Dr. G. Howard White, graduate of the Johns Hopkins Medical School and formerly Pathologist to the West Virginia State Hospital.

Dr. Henry L. Whittle, also a graduate of the Johns Hopkins Medical School and formerly connected with that institution and also with the Mt. Wilson Sanitarium for Children, will lecture on physiological chemistry.

#### HOSPITAL APPOINTMENTS.

The following members of the class of '10 have received hospital appointments:

#### MERCY HOSPITAL.

Entering in June, 1910: Dr. E. H. McDede, Dr. W. H. Hobson, Dr. E. T. Quinn, Dr. G. C. Blake, Dr. H. L. Brehmer, Dr. J. A. Rippert, Dr. B. O. McCleary, Dr. F. A. Duvally, Dr. H. E. Longsdorf, Dr. E. S. Stambaugh, Dr. A. J. Kimzey.

Entering December 1, 1910: Dr. A. W. Skilton, Dr. H. A. Bolton, Dr. N. A. J. Urbanski.

In addition to the above the following appointments have been made in other hospitals:

Dr. Roy Locher, St. Joseph's Hospital, Baltimore, Md.; Dr. A. C. Smith, Dr. Finkelstone, New York Lying-in Hospital; Dr. C. W. Daly, St. Francis Hospital, Hartford, Conn.; Dr. J. A. Burne, St. Michael's, Newark, N. J.; Dr. F. Steinke, Dr. J. M. Hanrahan, Alexian Brothers

Hospital, Elizabeth, N. J.; Dr. Walter D. Blankenship, Lancaster General Hospital, Lancaster, Pa.; Dr. Theron Roe, Relay Sanitarium; Dr. C. W. Maxon, Richard Gundry Home; Dr. J. McGinn, Dr. J. T. Powers, Bay View.

#### THE COMMENCEMENT IN 1874.

Dr. J. W. Baird, '74, of Waverly, Va., had the kindness to send on the programme of the annual commencement of the class of '74.

Prof. Opie made the annual report; Gov. Jas. B. Groome conferred the degrees, and Prof. E. Lloyd Howard made the valedictory address.

The Faculty at that time consisted of Edward Warren, Thos. Opie, P. Goolrick, John S. Lynch, W. W. Murray, E. Lloyd Howard, Thos. S. Latimer, Henry R. Noel, D. W. Cathell, A. F. Erich, Thos. R. Brown, A. Friedenwald, Chas. F. Bevan, and E. H. Rutledge.

In the class were: J. Waller Baird, Jas. O. Byrd, Jno. G. Christian, Jas. L. Craven, Rich. E. Cox, Chas. C. Duffy, Allen Gittings, Sam. T. Haffner, Silas W. Hunter, D. W. Hawthorn, M. F. Hansbrough, L. L. Johnson, Jos. B. Johnson, Oscar P. Lee, Henry N. Mohler, John P. Miller, Jno. D. Masengill, Wm. C. McCurdy, Robt. C. McCall, L. Sam. Mason, Jas. A. Summers, A. Stein, W. H Todd, Wm. W. Wilkins, Geo. S. Watson, Ed. N. Crawford.

Of these members we are able to locate only the following: M. F. Hansbrough, Front Royal, Va.; Silas W. Hunter, Parkton, Md.; W. O. P. Lee, Reynoldson, N. C.; Edwin N. Crawford, Cecilton, Md.; Jno. D. Masengill, Blountville, Tenn.; L. Sam. Mason, Yancyville, N. C.; Jas. A. Summers, Mooresburg, Tenn.; Wm. W. Wilkins, Eastville, Va.; G. S. Watson, Union Ridge, N. C.; J. W. Baird, Waverly, Va.; Wm. C. McCurdy, Md. Sam. T. Haffner died in May of this year.

ARLETA, ORE., September 30, 1910.

My dear Dr. Brack.—Enclosed find \$1.00 for my subscription to the Alumni Journal for 1910; was very glad to get the Journal out on this edge of the continent.

Wishing you and the old P. & S. all the success of which you are so deserving, I remain

Yours fraternally,

J. R. Robinson, '01.

### Obituary.

Dr. Frank Cecil Fenhagen, '75, died at his home in Baltimore, June 13, from nephritis, aged 55.

Dr. Benjamin Franklin Emrick, '81, died at his home in Carlisle, Pa., July 26, from heart disease, aged 50.

DR. FRANK B. Dodge, '80, a resident of Mount Morris, N. Y., for 28 years, died at Fresno, Cal., June 22, aged 70.

Dr. Henry T. Reinsel, '86, died at his home in Coraopolis Heights, Pittsburg, September 12, from heart disease, aged 51.

DR. CLARENCE ROBERTS CAMPBELL, '06, of New Bedford, Mass., died at the home of his brother in Provincetown, Mass., June 19, from pneumonia.

DR. JAMES FRANK GILLESPIE, '97, for many years a school teacher in Nova Scotia, died at his home in the Bronx, New York City, September 12, from heart disease, aged 41.

DR. GEORGE MURRAY STUART, '05, a member of the Medical Society of the State of Pennsylvania, is said to have been shot and killed in his apartments at Pittsburg, Pa., August 1, aged 27.

Dr. Amelio Preziosa, '09, died May 23, of pneumonia. Dr. Preziosa had made a remarkable success during the short time he had been in practice, and his untimely death is particularly to be regretted, inasmuch as he was engaged to be married shortly.

Dr. Wiley W. Tarter, '08, of Mellen, Wisconsin, died at St. Joseph's Hospital, Ashland, Wis., August 11, from injuries received by the explosion of a barrel of alcohol. The barrel caught fire in the rear of a drug store and the owner attempted to extinguish the flames, but not succeeding, he attempted to roll the barrel into the alley. Dr. Tarter came to his assistance, and a moment later the barrel exploded, covering him with the burning alcohol. Dr. Tarter will be well remembered as one of the popular men of his class and had only been practicing at Mellen since last January.

We regret to announce the death of Mrs. Emma I. McGraw, the wife of Dr. A. J. McGraw, '06, of Taunton, Mass. Mrs. McGraw had been married but a short time, and her death resulted from pleurisy.

### Personal Motes.

- F. ROMAN WISE, of York, Pa., has typhoid at the Mercy Hospital in Baltimore.
- J. H. STIENBERGEN, '09, has located in Asheville, North Carolina, where he will limit his work to obstetrics, gynecology and pediatrics.
- Dr. W. B. Hunter, '10, has been appointed Associate Professor of Pathology and Anatomy in the Atlanta College of Physicians and Surgeons.
- John C. Morfit, '95, has been appointed hospital commissioner of St. Louis, and will have charge of the reorganization of the new hospitals in connection with Washington University.
- Albert C. Crawford, '93, formerly with the Bureau of Animal Industry with headquarters at Washington, has been appointed Professor of Pharmacology at Leland-Stanford University, California.
- E. H. CARPENTER, '94, Oneida, New York, paid a short visit to Baltimore in September. He was very much interested in the changes that had taken place in the hospital and college since his last visit.
- James G. Riddick, '93, has been mayor of Norfolk, Virginia, for almost a decade, independent of the party of administration. Dr. Riddick has always taken particular interest in his Alma Mater and frequently attends the commencements. He was president of the Alumni Association several years ago.

Powhatan S. Schenck, '81, has been appointed health officer of Norfolk, Virginia. Dr. Schenck, after leaving Baltimore, removed to Petersburg, Virginia, where he remained for five years, during four of which he was president of its board of health and also a health officer. For some fifteen years he has been practicing in Norfolk, and for the past four years has been a member of the board of health and also city physician. He has also been the medical quarantine officer of Norfolk up to the time of his appointment as chief of the health department.

Dr. Schenck is eminently fitted for his duties, having given the subject of hygiene and municipal sanitation special study, and having taken postgraduate work at Harvard in preventive medicine. In discussing the outlook of the department he states that he is going to pay particular attention to the ordinances dealing with the health department, to pure food and milk, the handling of garbage, the destruction of the mosquitoes, and to deficient barber-shop sanitation.

### Correspondence.

Collingswood, N. J., September 27, 1910.

Dr. Chas. E. Brack, Treas.

My dear Dr. Brack.-Enclosed find check for \$1.00 for enclosed bill. This is the first bill I have ever received for JOURNAL, which has come to me rather irregularly, so if I owe any more, kindly send me a statement and I will remit for same. I am always glad to get the JOURNAL; it is the only thing left to keep me in touch with the old college. While I only spent my last year there, still I am greatly attached to the P. & S., and feel it is one of the best small schools in the country. I located here in this beautiful suburb of Philadelphia (on the Jersey side) seven years ago, and have been quite successful. I am at present Lecturer on Materia Medica at the Temple Medical School, Philadelphia. We have 5000 people here and seven physicians, two homeopaths and five regulars. Four of them are P. & S. men-Madden, '98; Day, about '91 or '92, Eliott and myself of '03, and one woman physician from Women's, Baltimore, 1907. So you see Baltimore schools, and especially P. & S., are well represented here. I hope there will be a 10th reunion of the '03 boys in 1913. I am Yours fraternally,

EDWARD B. ROGERS.

MONTANA STATE HOSPITAL FOR THE INSANE,

WARM SPRINGS, MONT., September 19, 1910.

Dear Dr. Brack.—Enclosed find money order for subscription to Alumni Journal. Our friend, Dr. Bancroft, resigned the 15th, and has opened offices in Anaconda, a nearby town, of about 10,000. Dr. H. A. Bolton, '10, from P. & S., arrived a few days ago to accept position as second assistant physician. We now have 800 patients and practice of surrounding country.

A. C. Knight.

Sedro-Woolley, Wash., September 25, 1910.

Dr. Charles E. Brack, Baltimore.

Dear Doctor.—I am enclosing \$2.00 for the JOURNAL. I am always very glad to see it, as we are to see old and dear friends. I was very sorry to learn of Dr. Dobbins' painful injury, and hope it did not keep him long from his work, and that he has fully recovered. Remember me to him and to the other gentlemen of the school, of whose kindness and teachings I have so many pleasant memories.

I am located in a town of 5000 and doing general practice, although I now lean more toward surgery than obstetrics.

With kindest regards to yourself and best wishes for the JOURNAL, I am, as always,

Yours sincerely,

WM. A. DORSEY.

SLATE RUN, PA., September 12, 1910.

Dr. Chas. E. Brack, Baltimore, Md.

Dear Doctor.—Enclosed find one dollar for Alumni dues and JOURNAL for 1910.

By the way, will you kindly remind the "boys" of '91 of the movement on foot for a reunion of their class at the next Alumni meeting in Baltimore. It seems to me that the class of '91 should not allow the twentieth anniversary to pass by without yelling together once more and celebrate the event in a manner that will be a credit to our class. Let us by all means put forth the necessary effort to make this an important and successful event.

Very truly yours,

W. E. DELANEY.

WINCHESTER, VA., September 26, 1910.

DR. C. EMIL BRACK.

Dear Brack.—As you will see, I have changed my address and am again a resident of Virginia. Have bought an old colonial house here and have moved in. Hope to spend the remainder of my days here. Come up to see us and bring Mrs. B. along. Mrs. S. will be glad to see her at any time. Regards to all the boys.

Very sincerely yours,

E. C. STUART.

CALAHAN, N. C., September 12, 1910.

DR. CHAS. EMIL BRACK.

Dear Doctor.—I was glad to receive your reminder of the past. I was thinking not long ago whether I had ever sent you the pay for the Journal, but I could not in my best recollection decide whether I had or not, as I am always sending for Journals and literature, and paying out so much, and after this I will try and not bother you to remind me of it. But am always glad to get something from you all. I am still trying to practice medicine and would like very much to come out and hear a few weeks of lectures.

I will close. Give my regards to all.

Yours respectfully,

J. M. CAIN, '79.

LOUISBURG, N. C., September 17, 1910.

DR. CHAS. EMIL BRACK, Baltimore, Md.

Dear Doctor.—Enclosed you will find check for \$3.00 in payment of subscription of the Journal of the Alumni Association of the College of Physicians and Surgeons for the years 1909-10-11.

With my best wishes for you and the JOURNAL, I am

Yours fraternally,

S. P. Burt.

BRUNSWICK, GA., September 8, 1910.

DR. CHARLES E. BRACK, Treasurer,

Alumni Association, College of Physicians & Surgeons, Baltimore, Md.

My dear Dr. Brack.—Herewith please find \$1.00 for my subscription to the Association Journal, which kindly mail to me at Brunswick, Ga.

Before leaving Baltimore last year I think I registered my address as Savannah, Georgia, as I thought of locating there then, so I suppose this accounts for my not having received any copies of the JOURNAL.

We have twelve physicians in this little town, and four of them are fortunate enough to be alumni of P. & S.

With best wishes, I am

Sincerely,

T. W. CAUSEY.

WAVERLY, VA., September 12, 1910.

Dr. Chas. Emil Brack, Baltimore, Md.

Dear Doctor.—You will find enclosed money order for three dollars to square up my dues to the Journal as per your statement.

My address is no longer Carsley, as the office at that place was closed to establish a rural delivery, and my address now is R. F. D. No. 2, Waverly, Va.

Enclosed you will find also a programme of 1874 commencement exercises. If you should know the address of any of the boys I would be glad to have it. I would also appreciate the return of the programme after you make a copy of it, if you should so desire, as it is the only one I have.

With best wishes for the school, I am

Fraternally yours,

J. WALTER BAIRD.

CONNELLSVILLE, PA., September 28, 1910.

Dr. Chas. E. Brack, Baltimore, Md.

Dear Doctor.—Enclosed find check for \$1.00, payment for the 1910 ALUMNI JOURNAL.

I find the Journal both interesting and instructive, and enjoy the personal notes very much.

I regret I cannot be with you for the convening of the thirty-ninth annual session, but in lieu thereof extend greetings to the Faculty and students, and wish you both a prosperous year.

Fraternally yours,

THOS. R. FRANCIS, '98.

LEWISTOWN, Mon., September 14, 1910.

DR. CHAS. E. BRACK, Baltimore, Md.

Dear Doctor.—Enclosed find Post Office money order for three dollars to pay for Journal for 1908-1909-1910.

I have a fine location and am doing well.

Dr. Deal is located in Butte and doing fine.

Kindest regards to all the boys.

Your friend.

A. C. BIDDLE.

WARRIOR'S MARK, Pa., September 24, 1910.

Dear Dr. Brack.—Enclosed please find my subscription to the Alumni Journal of \$1.00. Am always glad to get it and read it carefully, it gives a person a line on the doings of old P. & S., which I know is holding her own in every line. I believe it would be a good thing if the subscriptions were raised and the Journal published monthly. What say ye?

My best wishes for P. & S. and all connected therewith.

Yours very truly,

DR. H. C. WILSON.

DUQUESNE, PA., August 16, 1910.

DR. C. E. BRACK, Baltimore, Md.

Dear Dr. Brack.—Enclosed find check for two dollars (\$2.00) for value received in the form of the Alumni Journal, since 1908.

I certainly enjoy the topics contained therein, but wish a few additional pages of reading were added.

Give my regards to all the boys and do not miss the Elizabeth contingent. Hoping the Journal continues to prosper, I remain

Yours fraternally,

CHAS. W. COHN, '08.

COLUMBIA, N. C., September 22, 1910.

DR. CHAS. E. BRACK, Baltimore, Md.

Dear Dr.—Enclosed you will find check for \$1.00. Let the JOURNAL continue. I love to read it an keep in touch with the boys. I am doing very well here.

Best wishes.

Yours fraternally,

C. A. Flowers.

Mt. Arlington, N. J., September 19, 1910.

My dear Dr. Brack.—Enclosed you will find one dollar, the amount due for the Journal during the year 1910.

I find the JOURNAL very interesting as well as instructive, and wish to thank you many times for your kindness in sending it to me.

I remain

Very truly yours,

CHAS. D. GORDON, '09.

IRON RIVER, WIS., September 26, 1910.

Dear Dr. Brack.—I enclose a clipping concerning my brother's untimely death, which occurred at Mellen, Wis., where he had recently located and was practicing medicine. The accident occurred on August 10, and he died August 11, 1910. This was, indeed, a severe blow to me.

I would be pleased to have you publish such statement in the JOURNAL of his death as you may deem proper.

With kindest regards, I am

Sincerely,

J. W. TARTER.

HUNTINGTON, W. VA., September 26, 1910.

DR. CHAS. EMIL BRACK.

Dear Doctor.—Inclosed find check for two dollars (\$2.00) in payment for the Journal for 1910-11.

I was very much grieved to hear of the death of Dr. Howard, '79. But we are getting to be the old people now, though I can scarcely realize it. With best wishes, I am

Fraternally yours,

THOS. F. STUART, '79.

108 WASHINGTON STREET, NEWARK, N. J.,

October 5, 1910.

Dear Doctor Brack.—Am mighty glad to see the college standing so well before the State Boards, and hope soon to see the failures down to 5 per cent or less, and I know we will get there, as the high standard atmosphere permeates our school.

With best wishes, kindly remember me to Dr. Ruhräh.

E. W. Sprague, '03.

ANSTED, W. VA., August 4, 1910.

Dear Dr. Brack.—Enclosed find check for one year's subscription to the Journal of our Alumni Association. I passed the West Virginia State Board O. K., and am practicing with my father in my home town.

With kindest regards,

L. O. Fox, '10.

WESTERLY, R. I., September 15, 1910.

Mr dear Dr. Brack.—Enclosed find check for two dollars (\$2.00) for Journal.

I take great pleasure in reading the JOURNAL, keeping posted on all that is doing at "P. & S."

I sincerely hope all the 1901 fellows get together and have a reunion next spring in good old Baltimore.

With best wishes,

Sincerely,

JOHN L. MAY, '01.

NEWARK, N. J., September, 1910.

Dr. Chas. E. Brack, Business Mgr. Alumni Journal.

My dear Doctor.—Enclosed please find order for \$1.00 for the JOURNAL.

I receive it regularly and am very much interested in its contents.

I did very well during my first year, much better than I anticipated, thanks to the efforts of the Faculty. I have the deepest regards for them and sincerely wish to be remembered to all.

Yours fraternally,

431 Avon Ave.

JAMES S. HEWSON.

OSCEOLA MILLS, PA., October 8, 1910.

DR. CHAS. E. BRACK.

Dear Doctor.—Just received my bill for the Alumni, and inclose check for the same. I always enjoy reading the Alumni, especially the letters from my old college chums.

I am located in central Pennsylvania, and have a nice practice up here. I am close to some of the P. & S. boys.

With many thanks to all of my old professors at the P. & S., I remain,
Yours truly,

S. L. STONEBRAKER.

ELEANOR, Pa., September 14, 1910.

My dear Doctor Brack.—Enclosed please find check for \$3.00. The Journal is always welcome. Trusting that you are well, I am

Truly yours,

R. O. BLACKLOCK.

#### THE MANUFACTURE OF ANTITOXIN.

In the treatment of diphtheria the physician of to-day uses antitoxin as a matter of course. It is his first expedient and his last resort. He believes implicitly in its efficacy. But does he understand and appreciate all that is involved in the production of that antitoxin—the scientific knowledge, the skill, the caution, the minutiæ of detail? This thought is forced upon the writer through the perusal of a recent publication of Parke, Davis & Co., which deals in part with the subject of antitoxin manufacture. Here is a specimen chapter:

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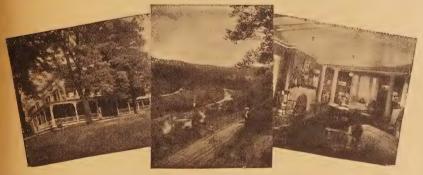
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THE OWEN BILL FOR THE ESTABLISHMENT OF A FEDERAL DEPARTMENT OF HEALTH, AND ITS OPPONENTS.

By S. ADOLPHUS KNOPF, M. D.,

Professor of Phthisio-Therapy at the Post-Graduate Medical School and Hospital, New York.

Anyone who is familiar with the workings of governmental departments of health such as exist abroad, who has seen or experienced the sanitary benefits bestowed upon the people by the Reichs-Gesundheitsamt of Germany (Imperial Department of Health), the Conseil Superieur de Sonté Publique de France, and the similar institutions of most European governments, cannot help feeling amazed that any opposition should exist to the establishment of a federal department of health in this country. This amazement becomes all the greater when one considers some of the elements of which the opposition to that measure is composed. There is, for example, the New York Herald, a large and influential newspaper with an honorable career and a brilliant record for advocating everything that is conducive to the public welfare. Only in this particular instance has it allowed itself to become the mouthpiece of principles to which it is in general opposed, that is to say, principles and measures whereby the good of the people at large and the progress and welfare of mankind are hindered, and the lives of individual American citizens endangered. This particular newspaper is independent of any political party, or professional or religious association which might prejudice its point of view, and still it opposes a measure whereby all citizens of the country would benefit. The writer cannot help thinking that this powerful news organ has not informed itself

thoroughly of the real purpose and function of a federal department of health, and in its attack upon a large body of men such as compose the American Medical Association, the American Public Health Association, the National Association for the Study and Prevention of Tuberculosis, the American Association for the Advancement of Science, and the various medical academies of the country, it is certainly misguided. It is to be hoped that the distinguished editors of the New York Herald will soon see that in their attitude toward the Owen Bill they are not on the side of the people, but are working against the welfare and interests of the masses.

The principle of the Owen Bill, establishing a Department of Health, has been endorsed by the President of the United States, by General George M. Sternberg, Surgeon-General of the Army (retired), and Rear-Admiral Charles F. Stokes, Surgeon-General of the Navy, by General Walter Wyman of the Public Health and Marine Hospital Service, by Dr. Harvey W. Wiley of the Bureau of Chemistry, by Governors of States, by the Conference of State and Territorial Boards of Health, by the United Mine Workers of America, by the National Grange, by the Republican and Democratic platforms, and by numerous other organizations.

What is the principle of this bill which is advocated by thousands of men trained in medicine or sanitary science and interested in the public welfare?

Section 7, which embodies the main purpose of the Owen Bill, reads as follows: "That it shall be the duty and province of such a Department of Public Health to supervise all matters within the control of the Federal Government relating to public health and to diseases of animal life."

Section 2 of this bill deals with the unification under a Secretary of Public Health of the various agencies now existing which affect the medical, surgical, biological, or sanitary service.

There has recently been formed an organization which calls itself "The National League for Medical Freedom." It has for its purpose to combat the Owen Bill; it is opposed to the establishment of a Federal Department or Bureau of Health. The name of this organization is certainly, if not intentionally, misleading. It cannot claim to battle for medical freedom, for there is not a word in the entire bill which could

be interpreted as limiting the practice of medicine to any particular school. Their claim that the establishment of such a bureau of health would have any resemblance to a medical trust is entirely unfounded.

The life insurance and industrial insurance companies which advocate this bill certainly have no desire to limit medical freedom or to repress any system which offers the chance of lengthening human life. These companies do not favor medical partisanship, and their sole interest is to prolong the lives of their policyholders by whatever means possible. Their actuaries state specifically that they believe human life could and would be lengthened by the establishment of a Federal Department of Health.

Lee K. Frankel, Ph. D., representing the Metropolitan Life Insurance Co., is a member of the Committee of One Hundred, appointed by the American Association for the Advancement of Science to further the propaganda for the establishment of such a department. Neither the above mentioned great newspaper nor any of the leading spirits of the "National League for Medical Freedom," all of whom, I regret to say, have allowed themselves to ascribe the worst motives to the members of the committee, will deny that the names of the officers of this committee show that it is thoroughly representative of the highest type of American citizenship. The officers of the Committee of One Hundred are:

President: Irving Fisher, Ph. D., Professor of Political Economy at Yale University.

Secretary: Edward T. Devine, Ph. D., LL. D., Professor of Social Economy, Columbia University, and Secretary of the New York Charity Organization Society.

Vice-Presidents: Rev. Lyman Abbott, D. D., LL. D., Emeritus Pastor of Plymouth Church, Editor of The Outlook; Jane Addams, A. M., LL. D., Founder and Headworker of the Hull House Settlement, ex-President of the National Conference of Charities and Correction; Felix Adler, Ph. D., Professor of Political and Social Ethics, Columbia University, Leader of the New York Society for Ethical Culture; James B. Angell, A. M., LL. D., Professor of Modern Languages and Literature, and President Emeritus of the University of Michigan; Joseph H. Choate, LL. D., D. C. L. (Oxford), Diplomat and United States Senator; Charles W. Eliot, A. M., LL. D., President Emeritus of the University of Harvard; Rt. Rev. John Ireland, LL. D., Archbishop of St. Paul; Ben B. Lindsey, Judge, Reformer and Author, Denver, Colo.; John Mitchell, President of the Labor Union of America; Wm. H. Welch, M. D., LL. D., Professor of Pathological Anatomy, Johns Hopkins University.

Need I say anything in defense of the Committee of One Hundred after having given the names of its officers?

Direct and most unkind comments not to use a stronger term, have been directed especially against one vice Stasident with the committee representing the medical profession. I refer to Dr. Wm. H. Welch, M. D., LL. D., President of the American Medical Association. Those who know Dr. Welch and even those who only know of him, would justly think it absurd if I should see the need to say even a word in defense of this master of medical science. To us it is indeed difficult to understand that there could be any man or woman in this land capable of speaking ill of Dr. Welch. There is no name in the medical world which is more honored in this country and abroad, no medical teacher more admired, no one who has a larger following than this Johns Hopkins professor of pathology, and no physician more beloved and looked up to as representing all that is best and noblest in the profession than Dr. Welch. there is any man in the American medical profession who is unselfishly devoting his high intelligence, his time, and his means to the public welfare, it is Dr. Welch. Gladly do we acknowledge him as our leader.

To accuse the president and members of the American Medical Association of selfish motives in advocating the establishment of a Federal Department of Health is absurd. If there ever was an unselfish movement inaugurated, it is this one. It is a movement by physicians for the reduction of disease which *ipso facto* means a movement against their financial interests.

The writer is a member of the regular profession; he nevertheless would not wish for a moment to limit the freedom of any citizen to choose his physician from some other school or cult, providing the individual assuming the function and responsibilities of a physician had the training necessary to prevent him from endangering the life of his patient by lack of medical knowledge or skill.

The official mouthpiece of this "National League for Medical Freedom" is Mr. B. O. Flower who had heretofore the reputation of a fighter for everything involving the spiritual, social and physical progress of humanity, and it is inexplicable to many of his admirers how he can lead a movement opposed to the improvement of the health of the nation. The vast majority in the ranks of this so-called "League," though they

may be well meaning, noble, and earnest, are not men and women who have toiled patiently for years in order to acquire the thorough scientific medical training which enables one to assume that great responsibility of the care and treatment of the sick. They are unable to appreciate the inestimable value of federal help in preventing disease. These people are blindly following certain individuals who designate the regular profession as a medical trust, and accuse the thousands of noble men and women who are devoting their lives to the alleviation of human ills of a desire to monopolize medical practice. The establishment of a Federal Department of Health would mean pure food, pure medicine, control of plagues and epidemics, the advancement of medical science and through it the improvement of the health and increase of material wealth of the nation. It is said that many of the individuals opposing the Owen Bill are commercially interested in the manufacture of drugs or patent medicines, of which latter the American people swallow about \$200,000,000 worth annually. Whether it is true or not that the National League for Medical Freedom is backed financially by drug manufacturers and patent medicine concerns, I am not prepared to say; yet even these men have nothing to fear from a Federal Department of Health if the drugs they put on the market are pure and the claims made for patent medicines do not delude the public or endanger its health. The element which clamors most loudly for medical freedom is composed in many instances of men and women who have attended one or two courses of lectures or got their "degrees" without any training at all, and have developed into "doctors" and "healers" in a most remarkably short space of time.

Because the American Medical Association has always advocated a thorough medical education, is pleading constantly for pure drugs, is opposed to quackery, patent medicines and nostrums, its 40,000 members are considered a medical trust. Yet it is in the ranks of this very American Medical Association that are found the greatest number of unselfish devotees to preventive and curative medicine. It is among this association that are found the men who have added the greatest glory to the medical and scientific reputation of this country. America's greatest surgeons—Marion Simms, Gross, Sayer, O'Dwyer, Bull—were members of this association. McBurney, Jacobi, Stephen Smith, Welch, Osler, and Trudeau have graced this association by their membership for

nearly half a century. The heroes in the combat against yellow fever—Reed, Lazare, and the hundreds of others who have devoted their best energies and knowledge and often sacrificed their lives for the sake of medical science were members of the American Medical Association.

One of the most illustrious members of the American Medical Association is its former President Col. William C. Gorgas of the U. S. Army, Chief Sanitary Officer at Panama, an adherent to the regular school. It is thanks to the genius, the scientific and thorough medical training of Dr. Gorgas that the formerly deadly Isthmus of Panama has now become as sanitary a region as any. A great patriotic enterprise, important to commerce and the welfare of nations, was made possible by this man. He has labored and is constantly laboring for the establishment of a Federal Department of Health because he knows the inestimable benefit which such a department would bestow upon the nation.

Whatever advance has been made in medical science in America or in Europe has been made by scientifically trained men or by physicians not without, but within the ranks of the regular profession. The greatest benefactors of mankind are those who diminish disease by prevention and cure. As another illustrious example of medical benefactors, may I be permitted to cite that great trinity of scientific giants who through their labors have accomplished so much in reducing disease and lessening human misery in all parts of the globe? They are Pasteur of France, Lister of England, and Koch of Germany; all of them aided their governments by direct participation in the governmental health departments. We are still mourning the death of perhaps the greatest of the three-Robert Koch. I do not believe that there is, even in the camp of our opponents in this so wrongly called "League for Medical Freedom," a single intelligent individual who will deny the inestimable benefits which Koch has bestowed upon mankind through his discovery of the germs of tuberculosis, of cholera, of the spores of anthrax, of tuberculin, and through his many other equally important scientific labors. Yet, had it not been for the Imperial German Reichs-Gesundheitsamt, which is the equivalent of the institution we are striving for-a Federal Department of Health-Koch never would have been able to devote his life, energy, and great genius to those important discoveries through which thousands of lives have been saved in all civilized countries during the past few

decades. It was while working in this governmental institution, which is doing exactly the work the Owen Bill asks the Federal Department to do, that Koch discovered the tubercle bacillus and the bacillus of cholera. Because of the discovery of the comma bacillus, we no longer have those fearful cholera epidemics which formerly decimated our own and other countries. This disease can now be easily diagnosed and by proper quarantine its mortality can be reduced to a minimum. And what shall we say of the progress that has been made in the fight against tuberculosis because the Federal Department of Health of Germany enabled Koch to do research work and thus discover the bacillus of tuberculosis to be the primary and only direct cause of the disease? As director of the Hygienic Institute and member of the Reichs-Gesundheitsamt he inaugurated that wonderfully effective campaign against tuberculosis whereby the mortality from this disease in Germany has been reduced to nearly one-half to what it was prior to the discovery of the tubercle bacillus.

Under Koch's inspiration and guidance and in the same institute many great scientific discoveries of incalculable value to humanity were made. Foremost among them are the works of Ehrlich, one of Koch's most celebrated pupils, who recently gave to the world a new remedy which promises to prove a specific in an affliction from which mankind has suffered for centuries.

As co-worker in the Kaiserliche Gesundheitsamt and the Institute for for Infectious Diseases, affiliated therewith, we must also mention Behring, the discoverer of the anti-diphtheritic serum. Thanks to the discovery of this serum thousands of young lives are now saved which would formerly have fallen victims to the terrible disease known as malignant diphtheria. This was made possible by the opportunity given to the workers in the Reichs-Gesundheitsamt and Imperial Institute for Infectious Diseases.

Can there be any better argument in favor of the establishment of a Federal Department of Health?

# A CURSORY REVIEW OF PULMONARY TUBERCULOSIS.\*

BY BITTLE C. KEISTER, A. M., M. D., ROANOKE, VA.

In view of the great importance attached to the subject of pulmonary tuberculosis in the recent past and the extreme and diversified theories and opinions held by eminent scientists, medical text-book writers and fellow practitioners of medicine, I come before you with some degree of trepidation in attempting to grapple with such a monster subject.

More than a hundred years this monster tyrant was recognized and treated as a contagious and dangerous disease, and its victims were shunned and rigorously isolated. These restrictions were enforced in Portugal and also in the city of Naples. The physicians were required by law to report all cases of consumption and were liable to heavy penalties for their failure to do so.

All consumptives, as previously mentioned, were isolated, and their clothing, the furniture of their rooms, and all the ordinary articles used, were destroyed after their death. The rooms were also thoroughly cleansed and purified. These laws were rigorously enforced for more than fifty years. (Bonny.)

Notwithstanding these facts, this great plague continued unabated and undaunted in its devastating career, spreading the death-laden germs throughout all Europe. These same restrictions, with many more added on, have, for the past quarter of a century been enforced in our own tubercular stricken country, and yet the great plague is still roaming, claiming his victims to the sad tune of one of every seven of the deaths that occur in the entire world from all causes including war, famine, pestilence and alcohol.

The every day experience of pathologists, connected with our leading scientific schools and institutes, in the recognition of healed and unsuspected lesions in the lungs and other parts of the body, is sufficient evidence to demonstrate the wide prevalence of non-active infections as well as the inherent powers of individual resistance.

Statistical observation concerning the frequency of tuberculous lesions, found during post-mortem inquiry have varied considerably, according to the thoroughness with which all parts of the body have been explored.

<sup>\*</sup> Read before the fortieth annual session of Medical Society of Virginia, at Roanoke, October 3-8, 1909.

During recent years these researches have been conducted in a more systematic manner than formerly, and reported cases of latent infection are far more numerous.

Naegeli's statistics upon this subject obtained from the critical study of five hundred autopsies at Prof. Ribbert's institute in Zurich, are particularly startling. After carefully inspecting every organ of the body including the lymphatic glands as well as examining a large number of microscopic sections, he reports the finding of tuberculous lesions in ninety-seven per cent of all the cases up to the fifteenth year, ninety-six per cent up to the eighteenth year, and nearly 100 per cent up to the fortieth year. These results apparently corroborate the popular German belief that every person possesses a slight focus of tubercular infection.

The obscure localized lesions, affecting the vast number of human beings compared with those actually succumbing to pulmonary tuberculosis, affords a striking commentary upon the effectiveness of self-immunization. In this connection it is not only necessary to consider the many individuals who perish annually from the disease but also the myriads of those whose capacity as wage earners is restricted. The number thus afflicted is truly appalling, and in nearly all countries, exceeds in economic loss and human suffering all other combined agencies which contribute to the pathos of fate.

When we consider the working power of labor which constitutes the chief commodity of State, it is not difficult to comprehend the tremendous depreciation of economic resources entailed by the ravages of such a disease. Even without regard to the magnitude and depth of human suffering, the deprivations and blighted prospects incident to prolonged illness, the dismemberment of families, and the agony of heart and mind, the glaring fact remains that the prevalence of pulmonary tuberculosis constitutes a national, a racial and a social problem, comparable to which none other is worthy of consideration. It has been carefully estimated that over 1,500,000 people are annually incapacited for work in the United States on account of this one affliction. One hundred and fifty thousand is a low estimate of the number of lives directly terminated in the United States each year by tuberculosis.

The average age at the time of death is computed at thirty-five years, thus enforcing an annual preventable loss to the nation of many years of

future industrial activity, approximating one-half of man's average existence. If the value, to the State, of each healthy inhabitant during the entire period of usefulness is estimated at \$1000, the economic loss in one year from deaths so premature will approach at least \$500 for each individual thus removed, making an annual drain of \$75,000,000 upon the United States from this source alone. This is entirely exclusive of the additional expense necessitated for the maintenance of charity organizations and the demands imposed by the disease upon private benevolence.

The above figures form a very conservative estimate of the potential loss each year in the United States from a cause admitted to be within the limits of prevention. The computation of many students of political economy and observers of medical conditions estimate the financial loss to this country as a result of tuberculosis, to vary from \$200,000,000 to \$400,000,000 each year. In New York City 15,000 people die annually from this disease and about an equal number die annually in the States of Illinois and Ohio. In New York City, in 1905, 32,000 cases of tuberculosis were reported to the board of health. In Austria the tuberculin test has recently been employed upon healthy soldiers, with a positive result in sixty per cent of those who were presumably well, thus demonstrating the fact that a latent focus of tubercular infection existed in each one of these apparently healthy soldiers.

If this test were used in this country among the apparently healthy no doubt a like result would be obtained. We can readily see how appalling this condition of things would appear, and how important it is for the medical profession to begin the great fight of educating the public along the lines of hygiene and sanitation as a preventive measure against the spread of tubercular infection.

When we consider the astounding facts that over one million human beings have this year of 1909 surrendered their lives to this arch enemy, including over one hundred thousand of our own people in the United States, twelve thousand in the City of New York alone, aggregating an average of about three thousand persons each day in the year, with a possibility of indefinite continuance of these conditions, is it not high time for every father, mother, and child to buckle on the armor of warfare to save our nation from parasitic decay and destruction?

I have endeavored to portray, in a conservative manner, the great havoc

that this greatest of all scourges is playing with the human family, and will now proceed to give a few additional ideas of the nature and chief characteristics of this malady before offering some plain but scientific facts for its prevention and extermination. Before going to war with so formidable a foe it might be well to ascertain, if possible, the strength and chief traits of our enemy, giving due consideration to the various lines of procedure, the modes of invasion, the habits and even the topography and climate of the country. Until this is done we cannot expect as good results from our efforts toward the overthrow of this king of all diseases.

We are all familiar with Dr. Koch's discovery of the bacillus tuberculosis in the year 1883, which revealed to the world not only the hiding places, but the habits, actual work-shops and full paraphernalia of this secret foe. By an original method of differential staining, Dr. Koch succeeded in isolating the tubercle bacillus and demonstrated its presence in infected areas in all parts of the body. Previous to this, characteristic tubercle formation had been recognized in the scrofulous affection of glands, bones and joints, although the precise infective agent had not been discovered. The recognition of nodules or tubercles in the lungs was obtained about the middle of the seventeenth century. At the beginning of anatomic investigation with the discovery of cavity formations and pus collections, numerous conjectures were offered as to the pathogenesis of the disease.

The first efforts toward the inoculation experiments were made in the beginning of the nineteenth century, but were not attended with clearly definable results. Virchow cleared the atmosphere to some extent by expounding the pathologic and histologic structure of tubercle. Villemin in 1865 conducted a series of inoculation experiments of the greatest value. In addition to introducing into animals an infective material obtained from tuberculous tissues and the sputum of consumptives, he injected into a second group some non-tuberculous pus, and in a third a caseous matter from tuberculous cows. A tubercular deposit was found after these injections, confirming the theory of the specific infectious nature of the disease.

It remained, however, for the distinguished Dr. Koch to demonstrate the absence of tubercle bacilli in other than tuberculous conditions. He even

accomplished the successful inoculation of animals from pure artificial cultures of tubercle bacilli, after the elimination of all extraneous elements, and the removal of all accessory sources of error. Dr. Koch thus established the real cause of tuberculosis among man and animals by the discovery of the bacillus and confirmed by the results of inoculation experiments.

The apparent etiologic identity of all forms of tuberculosis in different species was determined also upon the basis of the characteristic histologic structure of the primary tubercle. Recently a mass of evidence has been presented by numerous observers, both for and against the acceptance of essential differences in the cultural characteristics, virulence and powers of transmission. While we are of the opinion that human and bovine tuberculosis have the same origin and can be transmitted from one to the other, yet there is great room for speculation; but suffice it to say we are more interested in eradicating it from our fellow creatures, whose lives are more precious than gold or silver, than we are in eradicating it from the lower animals.

In this connection, if you will permit the digression, I am of the opinion that every up-to-date physician should be able to use and own a first-class microscope and an oil-immersion lens that he may diagnose his cases at his office instead of sending specimens off to the specialist. There is no good reason why every general practitioner who has any aspiration to keep abreast of the times, should not do his own bacteriologic work. The diversion from the routine part of his work and the fascination of spending at least one afternoon of each week in laboratory work, saying nothing of the consolation of being able to diagnose his own cases without outside assistance, is sufficient to amply reward him for the outlay in the purchase of a microscope with all the necessary equipment. Of course, if he expects to do good and satisfactory work, he should take a special course in microscopy and bacteriology, provided he did not get this knowledge in his regular college course.

In the study of the tubercle bacillus in its various aspects, we find some very important features to consider, not only in reaching a clear diagnosis, but also in making a prognosis. In studying the anatomy of the tubercle bacillus we find the length varying one-fourth to one-half the diameter of a red blood corpuscle. This difference in length and

shape varies with the virulence and stage of the disease. Short and thick bacilli indicate great virulence, and when clumped together in schools the virulence is even greater, while if the bacilli are long, flexed and scarce, it indicates a cronic condition of long standing. There is also a marked difference in the anatomy of bacilli from sputum and those from culture growth.

These little pointers I have learned partly from actual experience in my laboratory work since taking a special course in research work at the Pathologic Institute in Berlin, and consider them worth remembering.

Having in a crude way searched out the real cause and working force that destroy the living tissues of the vital parts of our organism (the tubercle bacillus) we will proceed to show some of the chief modes of contagion, the main routes and thoroughfares travelled by this marching army of destructive parasites whose camps and temporary abiding places are found in every nook and hamlet throughout the world. Only recall some of the myriads of sources from which this infection is carried and spread over the country. Go with me, if you please, to the work-shops, and the parasite-producing industries of our cities! First among these are the dust-producing trades which cause many of the various throat and lung diseases. Take the cement factories that are now springing up all over our country and whose business it is to manufacture dust. The workers are surrounded by and work in an atmosphere made foggy with small particles of quick-lime, which makes up the major part of the commercial product called cement. Add to this fact that the workers, in order to adjust the machinery, and keep the equipment going must be constantly exposed to the sheets of flame that keep the massive cylinders red hot, and you will have only a faint idea of the cement worker's life. The clouds of curling dust arising from these factories can be seen for miles away. This dust, when inhaled, produces an irritation of the mucous membranes of the mouth, nose and throat, and is also carried to the bronchial tubes and lungs, setting up irritation of these organs, and producing a raw surface for the direct invasion of the tubercle bacilli.

The cement factories of America might well be called the homes of tuberculosis. This applies with equal emphasis to the fertilizer plants, glass factories, cotton mills, coal mines, etc. In glass factories, children do a large part of the work, and while the father is breathing quick-lime

dust in the cement factory, his child is breathing pulverized glass in the glass factory. The one eats the tissues of the lungs, the other irritates them, until they are in a receptive condition for any germ disease. In the coal mines, while the fathers are being crushed, crippled and killed, their children are working in the coal-breakers above. For ten or eleven hours a day these children of ten or eleven years of age, stoop over the chute and pick out the slate and other impurities from the coal as it moves past them. The air around them is so black with coal dust that they are compelled to wear lamps on their caps at noonday in order to see the coal which is moving under their feet.

Many of these children contract miner's asthma, and finally develop pulmonary tuberculosis. There are now in this country forty-two thousand children employed in mines and quarries. Eighty-two thousand children are to-day breathing the lint of cotton mills in the United States. Five thousand three hundred and sixty-five are breathing pulverized glass from glass factories. Eleven thousand four hundred and sixty-two are steeping their system in the nicotine of tobacco factories.

In the laundries of our countries little girls and young maidens are standing all day sorting filthy linen, or feeding flat-pieces into a hot mangle where the heat is so intense that they are compelled to work almost without clothing. Many times they are worked far into the night and must return to their homes through the dark and deserted streets of our cities, and in all kinds of weather, uncared for and unprotected. We can readily anticipate the risks these young girls run in leaving these steam-heated apartments and rushing out into the crisp, wintry night air, trudging their way through the snow or rain to their respective homes in some distant and perhaps unsanitary part of the city.

Are these not favorable sources for the propagation and spread of tuberculosis? Those industries which employ little children just long enough to sweat out their vitality, leaving them diminutive little wrecks to drift aimlessly through a long, dependent life of poverty and disease, should be classed as social parasites and should not exist in any civilized country.

We might cite hundreds of such sources where the constitutions of the youth of our land are ground up in these mills of commerce. After going through these various processes of grinding there is barely enough constitutional vitality left to survive that age when tuberculosis and other contagious infections are most apt to attack and swallow them up. It is usually when the constitution is run down and at a low ebb that tuberculosis is most liable to be contracted. One of the chief characteristics of the tubercle bacillus is to grow and multiply when the soil is suitable. Weak constitutions furnish this kind of soil. We find these weaklings in all lines of trade, the great majority of whom, if put to the von Pirquet tuberculin test, will be found to have tuberculosis. These weaklings can be found in candy factories, where the fly is a constant visitor and onlooker and is ever ready to deposit his share of infection on the candy that we purchase from the confectioners.

Over half a million bacilli have been found in one fly speck, and his flyship is capable of carrying over 6,600,000 bacilli on his legs and wings. One person who has tuberculosis in the worst stage is capable of expectorating in a single day over one billion of the bacilli. We have similar conditions to the above in our bakeries, where possibly the head baker is a victim of tuberculosis, and with his usual domestic companions, the flies, contribute a large share of this infection, in the way of deposits, to the bread we eat on our tables. The same rule applies to our tailor-shops, where tubercular cutters or seamstresses are constantly, but unwittingly, infecting the clothing we purchase from them; the bargain counters in some of our large department stores, the "cheap john" clothing stores, the unsanitary confectionery and grocery stores, ice cream saloons, common restaurants, fruit stands and stores, moving picture and vaudeville play houses, waiting rooms and toilets in railroad stations and other public places, state rooms in steamships, and berths in Pullman sleepers. There are set free in the United States every year one hundred thousand prisoners from our jails and penitentiaries. Over twenty-five per cent of these have some form of tuberculosis, and are allowed to roam the country, spreading the infection as they go. When we consider a company of 25,000 advance agents from this one source spreading this deadly infection over our country should we not appeal to our national government for help?

These and thousands of other sources that could be mentioned in the same category, are the homes and common dwelling places of the tubercle bacilli. They are carried to these places by the victims of tuberculosis

and the common house fly. The infection, when once housed in a locality where the soil is favorable, is very hard to exterminate. The way by which this infection is spread and taken into the system is by the sputum of persons who have tuberculosis. This sputum after drying on the floor, sidewalk or street, is taken up as dust by a draught of air, or gust of wind and sent on its deadly mission, to be inhaled by any passer-by, and if lodged in suitable soil of the mouth, nose, throat or lungs, in the course of a few weeks or months these victims go out on the same mission spreading the same infection, as well as adding recruits to that great army of millions who have gone before to that bourne, whence no traveler returns.

Having merely touched upon the chief points of this mammoth subject, giving some of the leading characteristics that should claim the attention of the medical profession in the fight that is now being made, I shall conclude my paper by offering a few suggestions along the lines of prevention and extermination of this world-wide scourge that is now challenging the skill of the whole medical profession.

One of the strongest and most important preventive measures against pulmonary tuberculosis, is the careful management of the children of tuberculous parents or grand-parents. There is, beyond all question, a predisposition of this disease in such children, also in adults who are the off-spring of tuberculous parents or grand-parents. The constitutions and general welfare of this class should excite the interest of not only the immediate relatives and friends, but of the family physician as well. While I do not believe that the disease itself is hereditary, yet I am fully convinced that there is a strong hereditary tendency. When this tendency exists, accompanied by anemic conditions, low vitality, loss of energy, loss of weight, slight cough or constant clearing of the throat, dyspeptic symptoms, loss of appetite, tired feeling, slight evening fevers, etc., there is good ground for suspicion of beginning tuberculosis. Where there is much doubt and anxiety on the part of friends and relatives, it might be well to use the von Pirquet tuberculin test. If a positive result is found, this class of patients should take a course of building-up treatment until all the worst symptoms are cleared up; then advise a climate of pure, dry atmosphere in a high altitude, where such persons can spend the rest of their lives in ease and comfort following their ordinary avocations. This is the proper climate for all persons who have an inherited predisposition to pulmonary tuberculosis.

One other important preventive measure should be inaugurated in every country throughout the world. I refer to the prevention of marriage of all those who have pulmonary tuberculosis. While such a law, if inaugurated, might at first seem radical, yet it would prove a step in the right direction toward eradicating the disease and saving future generations from the blight of this curse. It is a well known fact that the married state hastens the progress as well as the spread of the disease. If we wish to be sure of success in our fight, we must use some strategy and diplomacy in searching out and capturing the victims who are the advance agents in the spread of this deadly infection. These should be caught, if possible, while in the incipient stage, and placed in sanatoria, where they can be treated scientifically until cured. Eighty per cent of all cases in this stage, who have fairly good constitutions, can be cured. In the other more advanced stages of the disease, the victims should not only be captured, but quarantined under the same restrictions that govern other cantagious diseases, such as scarlet fever, diphtheria, etc., none of which is comparable in death-spreading qualities to pulmonary tuberculosis. The question naturally arises, can these plans be carried into effect? Have we a right to curtail the privileges and rights of our fellowman along these lines? And is it humane to thus cut off from the social world, those unfortunate people of our own flesh and blood? These are the greatest, as well as the most far-reaching questions to answer in lining up our forces for the battle that is now approaching.

As previously mentioned, without a full supply of strategy and diplomacy, these plans cannot become effective, notwithstanding all the combined forces of the medical profession, backed by the governments of the respective nations of the entire world. The three most important essentials in this fight are education, means, and diplomacy. Education is necessary for the victims of the disease, for the general public, and for those who are expected to do the fighting. Educate the consumptive by telling him first of his real condition, and then teach him to co-operate in arresting his disease and preventing the spread of his infection to his fellowman. Teach him the laws of self-preservation, habits of cleanliness, personal hygiene, and how to avoid taking cold, and to live an out-of-doors life in suitable weather, both day and night, wearing suitable apparel for body warmth, to take tepid and friction baths, to regulate a

diet that will sustain and nourish all the organs of the body, and to keep the secretions and excretions in as normal a condition as possible, avoiding all things and influences of a deleterious or depressing character, and seeking those influences that are elevating and of a cheerful nature; administering only such medicines as are indicated by the symptoms of each individual case.

We have in guaiacol and iodine, with their respective derivatives, two of the best and most suitable medicines for the treatment of this disease that have as yet been discovered. When properly compounded, they can be used by forced inhalation, as well as taken internally and externally. With the proper administration of these two germicidal weapons, reinforced by a bounteous supply of pure, fresh air and wholesome nourishment, any ordinary case in the incipient stage, should be arrested within twelve weeks.

Teach the patient the use of the thermometer, that he may keep a record of his most important symptoms, reporting same at regular intervals, and to avoid taking active exercise when his temperature is at or above 100 degrees. In short, give him a full set of specific rules and regulations in type-written form to follow, and instruct him to impart these to his friends and acquaintances who may be victims of the same disease.

We should also educate the immediate relatives and friends of the patient, as well as the general public, along the lines of hygiene and sanitation. The starting place toward educating the masses is in the public schools. One week in every three months should be devoted exclusively to the study of hygiene and sanitation, in addition to those studies in the regular curriculum, requiring each teacher to prepare a special course to be taught to all the pupils, both small and large, during these special weeks. The teachers should also require the pupils to recite to their parents the same lessons on hygiene and sanitation that are recited to them, and in this way educate parents as well as children on these important subjects preparing them as if for a "thirty years' war." The play grounds should be carefully selected and the importance of open air exercise impressed upon each pupil of the school. These principles should also be taught from the rostrum and the pulpit by men fitted for this purpose. Education, as previously mentioned, is only one of the main essentials toward the prevention and extermination of this dread disease.

The next important essential is the *means* by which to establish sanatoria for the three classes of patients who are victims of this disease in its three respective stages. There should be in each county or city of 50,000 inhabitants, three sanatoria—one for those who have tuberculosis in the incipient stage and are curable, one for those who have the disease in the second stage, with a possible change of arresting it, and one for the third or incurable stage.

Where it is feasible, several counties or cities might combine funds and establish these sanatoria under a joint corporation. These sanatoria should be established by the State governments, assisted by the national government, hence the importance of legislation! Let the medical profession as a unit work to this end and it will be only a matter of time when the laity will fall in line and thus assist in taking the matter up with our law makers.

To accomplish all this it will be necessary to use a large amount of diplomacy. The best talent, tact, and influence should be brought to bear upon the laity, the law makers, the public benefactors and the wealthy consumptives of this country. This latter class may not be disposed to give up their individual rights and privileges for the mere sake of humanity by condescending to live in a public sanatorium, yet if the proper influences are brought to bear upon this class, and with some diplomacy, we may not only conquer them along the line of submission to certain rules and regulations of the open air sanatorium, but we may, by conciliation, induce them to give a part of their means toward the equipment and endowment of these humane institutions.

In this connection I would suggest that a special committee of two well-known members of this society be appointed from each county in the State, to act in conjunction with our legislative committee in bringing the matter of establishing county sanatoria before each of our county legislators, State senators, the Governor of the State and some of our wealthy public benefactors, reporting the results of their efforts at the next meeting of this society.

#### EXTRA-UTERINE PREGNANCY.

BY DR. JAMES J. BOUCHER, '04, HARTFORD, CONN.

Extra-uterine pregnancy might be defined as that form of pregnancy in which all the fecundations are situated outside of the uterine cavity. From an anatomical point of view we might subdivide this condition into several varieties but clinically such subdivisions are unnecessary.

Tubal pregnancy occurs as the most frequent form of ectopic gestation. Extra-uterine pregnancy occurs in about one per cent of all pregnancies and in about five per cent of all laparotomies it is found, some observers place the average as high as seven per cent.

The causes of extra-uterine pregnancy are not well defined. It is a pretty well established fact that the meeting of the ovum and spermatozoa takes place in the tube and that fertilization normally occurs at this point; every pregnancy being therefore, primarily, tubal. The location of a tubal pregnancy may be either in the interstitial, isthmic or ampullar portions of the tube. The interstitial is the least common, while the isthmic form occurs most frequently.

In extra-uterine pregnancy there are usually two methods of termination, either tubal abortion or tubal rupture.

Tubal abortion may be either complete or incomplete. Abortion is brought about by the separation of the placental site from the tubal wall as a result of hemorrhage due to the sudden opening of the maternal vessels by the growing trophoblast and chorionic villi.

If the separation is complete, the effused blood gradually forces the ovum towards the fimbriated end of the tube, through which it is extruded into the peritoneal cavity, when the hemorrhage usually ceases. If the separation is only partial, the ovum remains in situ, and the hemorrhage continues. Absorption is usually the fate of small embryos, which are extruded into the peritoneal cavity, unless the placenta retains its attachment to the tube and offers conditions suitable for the continuance of the circulation. Let us consider for a moment the difference between tubal abortion, where the tubal contents are extruded through the fimbriated end of the tube into the peritoneal cavity and tubal rupture. Owing to the relative paucity of the decidual cells, the changes following implantation of the ovum differ from those occurring in normal uterine pregnancy. As there is no distinct decidual membrane to sepa-

rate the growing ovum from the underlying muscular and connective tissue, the rapidly proliferating trophoblast comes at once in contact with the tube wall and promptly leads to its necrosis. As this tissue offers but slight resistance to the growing fetal elements, the chorionic villi within a short period of time extend through the entire thickness of the tube wall and come to lie just beneath its peritoneal covering, so that perforation becomes imminent. The maternal vessels are opened up rapidly with the result that in many cases sudden hemorrhage occurs beneath the ovum separating it from its attachments and causing abortion, or if any obstruction exists to the escape of the blood through the fimbriated extremity the thinned out wall ruptures.

Under the influence of ectopic gestation the endometrium of the uterus becomes converted into a decidua similar to that found in uterine pregnancy. Soon after the death of the fetus, the decidua is thrown off in small pieces, occasionally as a cast of the entire uterine cavity. Its discharge is usually considered of marked diagnostic significance, so much as that in doubtful cases many surgeons have recommended curetting the uterus, and base their diagnosis upon the presence or absence of decidual tissue. The presence or absence of this decidual tissue is, in my opinion, a very important point, and while not a positive sign, is one that should not be overlooked. In one of our series of cases such decidual tissue was thrown off from the uterine cavity, and at first led me to believe that a miscarriage had taken place, but later proved to be a ruptured tubal pregnancy. When we recall the comparative high percentage of extra-uterine pregnancies (one per cent) we should be constantly on our guard not to mistake or overlook this condition for a miscarriage. I believe one should always observe the presence of the fetal structures personally before accepting the idea that the case under one's care is a miscarriage, and in the event of such inability one should make a careful bi-manual examination under strict antiseptic precautions, to determine the presence or absence of a tubal gestation. Why, then, does not the fertilized ovum remain within the tube, and develop there in all cases, instead of passing back into the uterus? Granting that the normal place of fertilization is in the tube, we might assume that it is due to the fact that in the absence of any pathological change in the tube, the ciliated epithelium with which the tubes are lined and whose current are down-

ward towards the uterus, favor the passage of the impregnated ovum into the uterus. Some of the conditions supposed to bring about a tubal pregnancy are (a) any condition which interferes mechanically with the downward passage of the ovum; (b) those resulting from inflammatory diseases of the tubes, ovaries, and pelvic peritoneum; (c) physical and developmental abnormalities which favor decidual formation in the tubes; (d) it has been found that the tubes possess small diverticular, some of them extending through the muscular coats of the tubes, almost to the peritoneal covering, and one could conceive that an ovum which had become lodged therein might under favorable conditions develop at this point within the tube. One point seems fairly certain, that the fertilized ovum may be arrested at any point on its passage from the graafian follicle to the uterine cavity and undergo development in the ovary or tube, and thus give rise to ovarian or tubal pregnancy. It is extremely doubtful whether the ovum can become implanted upon the peritoneum and a primary pregnancy follow. Veit claims that an abdominal pregnancy is always secondary, that the ovum will not develop upon a peritoneal surface alone, and that no case of primary abdominal pregnancy has ever been authentically proven.

If rupture of the tube occurs, the ovum is expelled into the peritoneal cavity, and usually perishes. If the embryo is very young, it may be absorbed. On the other hand, when the fetus has attained a certain size before death, it cannot be absorbed in this manner, and must undergo supperation, mumification, lithopedion, or adipocere formation. I recall one case where we found a lithopedion in which tubal abortion or rupture had probably occurred over one year previous. The collateral changes in the uterus during ectopic gestation are the same to a certain point as those found in normal pregnancy, even to the formation of a decidual vera. If the ovum dies, these changes are arrested, although at a much slower rate than in extra-uterine pregnancy. The decidua do not keep pace with the uterus and are usually thrown off at an early period in bits or en masse simulating abortion.

Symptoms.—Unfortunately most cases of extra-uterine pregnancy are not diagnosed until rupture has occurred, owing to the fact that the physician is not called until this unfortunate complication has taken place. Ordinarily, the patient so affected considers herself pregnant.

There may be present the usual subjective symptoms; on the other hand, she may have no idea she is pregnant, and rupture may occur before she has missed a single menstrual period. Suppression of the menstrual flow has been noted by many observers in from 40 to 50 per cent of the cases. In many of these cases, the first manifestation of extra-uterine pregnancy is the sudden occurrence of intense lancinating pain in either ovarian region, followed by faintness, the patient rapidly passes into a condition of collapse. This indicates abortion or rupture. If an abortion has taken place, the patient usually rallies promptly; whereas, if rupture has occurred the collapse deepens, the face becomes extremely pallid, and the patient complains of intense pain in the lower abdomen. The temperature is usually sub-normal, and blood examination shows a marked diminution in the number of red blood corpuscles and the amount of hemoglobin. If a patient presenting the usual subjective and some of the objective symptoms of pregnancy be examined and a unilateral tubal tumor be found, the diagnosis is fairly certain, especially if sterility has persisted for a number of years, or a long interval has elapsed since the last pregnancy. In these cases there is usually some enlargement and softening of the uterus, and the tubal, tumor is soft and doughy. For these reasons one should always before emptying the uterus for supposed incomplete abortion satisfy himself that no tubal tumor exists.

The diagnosis of tubal pregnancy can usually be safely made whenever a patient who is believed to be pregnant has complained of pain in the lower part of the abdomen, suddenly becomes faint, deathly pale and collapses. We should always remember that in the case of a woman during the child-bearing period with the history of a sharp pain in the lower abdomen, associated with collapse, and symptoms of abdominal hemorrhage, ruptured tubal pregnancy or tubal abortion is an important factor, which we should determine whether or not is present. When one does not see these patients in the original attack, and when they have recovered from the primary symptoms, the history of the case is of the utmost importance. Under these circumstances, on vaginal examination one will find a mass on one side of the uterus, which may be mistaken for an inflammatory pelvic tumor, unless a clear history of the primary attack is obtained.

Appendicitis may at times be mistaken for right-sided extra-uterine

pregnancy, or the opposite error may occur. In inflammation about the appendix, if an exudate is present, it will be more likely to be situated higher up in the pelvis toward the iliac fossæ. There is always a febrile condition in appendicitis and none of the symptoms of pregnancy are found unless pregnancy and appendicitis co-exist. A careful history will always show a marked difference. A perforative peritonitis might resemble a ruptured tubal gestation with profuse internal hemorrhage, both conditions being associated with intense abdominal pain followed by collapse. In appendicitis with perforation, however, there will be an absence of the symptoms of profuse internal hemorrhage, the anemia which is present in tubal rupture and the peculiar facial expression in peritonitis. With a given case, however, even the most expert diagnostician may err.

We now arrive at the most important part of my subject; namely, the treatment, and my chief reason for bringing this subject before you is to bring to your notice some important points which I believe to be based upon sound reasoning and common sense. I propose to advocate the conservative treatment in this class of cases, and endeavor to show why the radical early operation in all cases is open to severe criticism. Frederick, of Buffalo, reports a series of 125 cases of ruptured tubal pregnancy, in six of which only was the hemorrhage severe enough to endanger the life of the patient. Three were in extremis when seen, and were immediately operated upon, and all three died notwithstanding that the operation was rapidly done. His conclusions are that only a very small percentage of ruptured tubal pregnancies are immediately dangerous to life from hemorrhage, probably not over 5 per cent. Boldt, of New York, whose experience in this class of work has been almost unlimited, says: "An analysis of the cases in which there was profound collapse from internal hemorrhage, but nothing in the history which pointed to a previous intraperitoneal hemorrhage, shows that by far the greater majority rally from the bleeding sufficiently to come well out of the shock. To operate upon a patient in profound collapse from primary hemorrhage, is in my opinion a mistake, because with proper treatment the patient may rally in a few hours." I am well aware that the great majority of surgeons advocate immediate operation in this class of cases, but the very fact that many cases of extra-uterine pregnancy are not

diagnosed for many hours or days after rupture and recovery from the effects of the primary rupture takes place, proves that undue haste in operating is entirely unnecessary. I think a general surgical principle that one can safely follow is to tie a bleeding vessel for the relief of the hemorrhage; but in this class of cases will we find a bleeding vessel when we open the abdomen, even in the presence of sharp rapid pulse and anemia. I think that in the vast majority of cases we will not, the bleeding having ceased.

In our own work upon this class of cases we have never yet seen a bleeding vessel, much less a spurting one, and I believe that many cases that are claimed to be in the stage of active hemorrhage when the abdomen is opened, is due to the fact that the tension on the blood clot within the sac is relieved and thus allows fresh bleeding to go on, or manipulation of the mass has started fresh hemorrhage anew. My own experience in this respect is also the experience of Dr. Robb, who reported a series of 50 cases without having found in a single instance active hemorrhage present. If active bleeding was going on into the free peritoneal cavity from the moment of rupture, it is only reasonable to suppose that many more of these patients would die than we find to be the case. Stillwagen, in a large series of cases, says he has never seen a case of fatal hemorrhage. While we must admit that fatal hemorrhage does occur, are we able to judge which cases will prove fatal, and in the presence of shock and collapse can we do more than nature will do if left undisturbed? Admitting that 5 per cent are fatal, unless we can reduce that mortality by surgical intervention, are we justified in operating and reducing the little chances that the patient may have in her favor? I believe not. It has been determined that about 75 per cent of cases terminate in tubal abortion. The bleeding is not usually great, and the entire mass is rapidly walled off by adhesions. Delay in these cases can surely do no harm. Of the remaining 25 per cent, a certain number rupture into the broad ligament, which is the safest of all terminations. The balance, about 20 per cent, ruptures squarely into the peritoneal cavity. This is not a much greater percentage that the present mortality rate. Neugehauer had one death in 135 cases treated expectantly, and says: "Every surgeon ties a bleeding vessel at once." By the expectant method of treatment Winkels' mortality was nil; that of Winter

nil; Thorn, 1 per cent; Hunter Robb lately reports 20 cases with one death. In our own series of 21 cases we have had two deaths, both of whom were operated upon when in a condition of collapse. These two deaths occurred early in our work, and before we were in a position to note the great advantages to be obtained by the expectant plan of treatment. Since that time, we have abandoned the early radical operation. Stillwagen believes that it is the invariable rule for hemorrhage to cease, and is firmly convinced that patients with sufficient resistance to survive the immediate effects of rupture rarely died under appropriate treatment. The firm blood clot, the intestinal adhesions, and the alert omentum so limit the blood space as to preclude the probability of fatal hemorrhage. The ovarian artery is rarely involved in the pregnant tube, the intense hyperemia is the chief source of hemorrhage, which may be expected to be severe while it lasts. The ragged nature of the wound facilitates clotting, and the clot itself often exerts sufficient of the above mentioned factors to stop bleeding. The treatment of terminated ectopic pregnancy, owing to its frequent occurrence is of serious importance, and on account of the almost universal teaching that immediate operation is imperative, a teaching which I believe to be wrong, based on a fallacy, and exceedingly dangerous.

Of the mortality we cannot speak with positiveness, but Noble reports 42 per cent in immediate operation, 11 per cent in all cases. Dudley says: "The prognosis in the most desperate cases is not hopeless." And he reports two cases which were in a condition of extreme collapse in which he did not feel justified in operating upon, both of whom recovered and did not have a later operation.

What, then, is the cause of death in these fatal cases? Do they actually bleed to death, or is death the result of other causes? We must bear in mind that shock and collapse occur almost simultaneously with the occurrence of rupture and before sufficient time has elapsed for much hemorrhage to occur, while the symptoms present are usually out of proportion to the amount of blood lost. Shall we resort to operative measures at this time? We must admit that this is a most serious time to open the abdomen, and I believe that all surgeons are agreed that there is no more unfavorable time in which to enter the peritoneal cavity than when the patient is in a state of collapse and suffering from shock.

Let us consider for a moment the different modes of termination of tubal pregnancy. It is a well established fact that from 75 to 78 per cent end in tubal abortion; that is, extrusion of the tubal contents through the fimbriated end into the peritoneal cavity, that this usually occurs between the first and third month, that no blood vessels of importance are involved, and that little hemorrhage is likely to occur. This leaves from 22 to 25 per cent to end in rupture through the tube, and this is the form in which hemorrhage is most likely to occur, and that will be most likely to tax the best judgment of the surgeon.

If the general condition of the patient shows an improvement, we should not operate then, but wait until she has more fully recuperated, if this seems likely. It is more rational to wait for three or more hours until the patient's condition has improved so markedly, judging from the pulse, respiration, condition of the skin and general mental condition, so that a rapid operation may be done with comparative safety. I fully realize that the expectant plan of treatment has been severely criticized and characterized as dangerous teaching, as a step backward, but I believe that the future will show results so striking as to prove it to be a decidedly safe teaching and well marked forward step in the already brilliant history of gynecological surgery.

I trust that my paper will not be misinterpreted. I believe we should operate on all cases of extra-uterine pregnancy as soon as the diagnosis is made if rupture has not occurred, on all cases without exception in ruptured pregnancy as soon as the patient is in a reasonably safe condition to withstand the shock incident to a laparotomy. I believe we should not operate upon a patient who is in a condition of collapse and shock, and while they may die without operation they will in all probability die if we operate. We must bear in mind that nature will, if left alone, restore many patients, which at the time we may look upon as hopeless cases. Furthermore, we should not lose sight of the fact that surgery will not cure all. I will not burden you with the details of the surgical technic, but will dismiss the subject by saying that I believe these patients will be benefitted by stimulation and saline infusion from the moment we see them, and not wait until after operation on the theory that the blood pressure will be raised and start bleeding anew.

#### A FEDERAL DEPARTMENT OF HEALTH.

We print in this issue an important contribution by Dr. Knopf on the subject of a Federal Department of Health. It is scarcely necessary to say anything further concerning the importance of this subject which ought to appeal to every one, but we do wish to call attention to the fact that in order to secure the passage of the Owen Bill it will be necessary for the medical profession, as well as the people, to stand ready to endorse it on every occasion.

It has often been said, and very truly, that in the United States we take more care of our cattle and domestic animals than we do of human beings. A very striking instance of this is the comparatively recent epidemic of foot and mouth disease in Michigan where within an incredibly short time after the first announcement of the presence of the disease, a small army of government experts were on the spot, and this disease, which threatened for the moment the animal industry, was promptly stamped out. We commend to our readers the article by Dr. Knopf.

#### CLASS REUNIONS.

A number of the Alumni have written at various times concerning reunions of their classes, and we have published from time to time these announcements. In order to have a successful class reunion it is highly important that an active committee be in charge, and that each member of any particular class appealed to respond at once saying whether he will or will not be present, negative answers being fully as valuable to the committee as positive ones, although, of course, a committee prefers to receive the latter. It is impossible to hold a successful reunion unless each member of the class takes interest enough to respond. In case you are uncertain as to the proper person to address your reply to, send it to Dr. Charles Emil Brack, 500 E. 20th St., who will turn it over to the proper committee.—A notice in the Journal is a personal appeal to each alumnus and should be treated as such.

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### THE JOURNAL

### OF THE ALUMNI ASSOCIATION

OF THE

# COLLEGE OF PHYSICIANS AND SURGEONS, BALTIMORE.

#### DR. WILLIAM SIMON.

The Research Club, which consists of some twenty members of the faculty and adjunct faculty, decided to issue a second volume of reprints of articles published by the members during the past few years, and this volume will be inscribed to Dr. William Simon, professor of chemistry.

The committee in charge of the getting up of this volume is composed of Dr. Harvey G. Beck, Dr. Harry Friedenwald, and Dr. John Ruhräh. The introduction to the volume is as follows:

There are but few men in the college who have lived as long as Dr. Simon and who have made as many fast friends as he. There are few men who possess the charming personality and the gift for keeping friends after they are first made, and this is perhaps one of Dr. Simon's distinguishing characteristics, and it is because he has endeared himself to the some three or four thousand graduates of the College of Physicians and Surgeons, that the Research Club have thought it particularly fitting at this time, when his birthday is fast approaching, to inscribe to him this volume of reprints which represent the contributions to medical science for the past few years of the workers in the hospital and the laboratories.

It is customary in volumes of this kind to preface the scientific articles with a few words concerning the individual they have intended to honor, and the committee find it difficult indeed to say about Dr. Simon all that they would wish and, indeed, to those who know him any word is more or less superfluous, and it is more for the benefit of those who have

never sat in his lecture room nor worked in his laboratory that these few facts are presented.

Dr. Simon was born at Eberstadt, Hessen, Germany, on February 20, 1844. He was the son of the Reverend William Simon, and his mother's maiden name was Agnes Briegleb.

His preliminary education was received in the schools at Giessen, and he spent the time from 1852 to 1860 at that place. The next six years were spent working in a pharmacy and in study, and in 1869 he received the degree of Ph. D. from the University of Giessen. The same year he was made assistant to Professor H. Will, the famous German chemist, and he worked in the same laboratory that had been used by Liebig, which was the first chemical laboratory to be established for research work in the world. The breaking out of the Franco-Prussian War in 1870 interfered with his chemical studies and he entered the army in that year. After a short period of service he came to the United States where he has resided ever since.

On his reaching the United States he secured the position of chemist to the Baltimore chrome works, which position he held constantly until he resigned in 1907. In 1873 he married Miss Paula Driver, who is still living. In 1872 he began to teach chemistry in the Maryland College of Pharmacy and held the chair of that science until 1902, when he resigned. During the first session of the College of Physicians and Surgeons, in the winter of 1872-1873, he delivered the first course of lectures, but it was not until 1880 that he returned to the school as professor of chemistry, which position he still holds. In 1888 he became professor of chemistry in the Baltimore College of Dental Surgery and still lectures in that institution.

Dr. Simon is a member, fellow or honorary member of most of the more important chemical and pharmaceutical societies, and has been honored by the position of president of the Maryland Pharmaceutical Association.

As a writer he has been a frequent contributor to the various pharmaceutical and chemical journals, but his chief claim as an author is in his "Manual of Chemistry" which was first published in 1885, and has subsequently gone through eight editions. This justly famous manual was published by Lea Brothers and Company now Lea and Febiger of

Philadelphia. The first edition of this work was a triumph in medical book making in that the colored plates used to illustrate the various chemical reactions were all colored by hand, and were regarded as being unusually accurate. These same plates served as a basis for the lithographs used in the subsequent editions for the same purpose. This manual of chemistry is remarkable for its wonderful clearness of style and the simplicity of its explanations, these two facts rendering it especially valuable as a text-book for medical students, and it has been used by thousands and thousands throughout the country as is attested by the enormous sale which far exceeds 50,000 copies.

If one were asked how old Dr. Simon is, they would be tempted to say that he was 66 years young, and the secret of his youth has been perhaps partly due to his many active interests. Few individuals have had as many delightful hobbies as Dr. Simon, and few have managed to enjoy them and also to allow their friends to share their benefits as he has. One after another of the interesting scientific things has claimed his attention, and one after another delightful public lecture or private demonstration has followed his researches. It would be like a catalogue perhaps to name these, and only one or two need be mentioned as examples.

A few years ago when liquid air was the current topic in the scientific and lay world many will remember the really wonderful demonstrations that Dr. Simon gave to the astonishment and delight of the thousands of people who heard him. More recently the marvels of color photography have been made plain by his illustrated lectures on the details of this beautiful art which he has mastered to a remarkable degree. Not only color photography but ordinary photography has claimed Dr. Simon's attention and his collection of photographs and negatives taken both at home and on his travels is well worth the journey to see. Dr. Simon's special knowledge of chemistry and physics has enabled him to secure results which to the ordinary amateur, nay even to the professional, are denied.

Dr. Simon has been a great traveler, and, in company with his wife, has journeyed much in this country and abroad, and, as a result of these wanderings has brought back a mind stored with the choicest recollections and a suit case full of photographic slides. His summer in the Yellow-

stone Park will be long remembered, not only by himself, but by the many auditors who were fortunate enough to hear his descriptions. And so we might run on for many pages telling one after the other of the things that have claimed his attention, and subsequently delighted his friends.

To Dr. Simon the members of the Research Club extend their heart-felt wishes for many more years of happiness and prosperity, and we wish him to feel that each word in this volume represents a message of love and affection from his students and friends, and if these feeble gropings after the truth fulfil no other purpose than to express to Dr. Simon our appreciation of him and his works they will have more than repaid the writers for their toil.

#### RAILWAY SURGEONS' ASSOCIATION.

A joint meeting of the two Railway Surgeons' Associations—"Pennsylvania Lines East of Pittsburg" and "Pennsylvania Lines West of Pittsburg"—was held in the University Club, Pittsburg, Penn., October 3 and 4, 1910. Dr. Jos. M. Wells, of Trenton, N. J., presided.

The following was the Scientific Program: Address on Surgery—Dislocations, J. William White, M.D., Chief Surgeon, Lines East; Burns and Their Treatment, A. W. Colcord, M.D., Clairton, Penn.; A Railroad Stretcher with Equipment, showing model, Edmund C. Brush, M.D., Zanesville, Ohio; The Use of Lanes' Bone Plates (Report of 25 Cases), W.O. Sherman, M.D., Chief Surgeon, Carnegie Steel Co., Pittsburg, Penn.; Fracture of Patella, J. J. Buchanan, M.D., Pittsburg, Penn.; Ultimate Cellular Nutrition The Chief Factor in Vital Resistance, W. H. Hay, M.D., Youngsville, Penn.; The Company Surgeon, His Work and Responsibilities, William Martin, M.D., Bristol, Penn.

At the Informal Dinner and Social Session on Monday evening, Dr. S. M. Free acted as toast-master and Dr. Jos. M. Wells read the president's address. Numerous speeches were made by those present.

The following officers were elected: President, Dr. Spencer M. Free, DuBois, Penn.; First Vice-President, Dr. H. T. A. Lemon, Washington, D. C.; Second Vice-President, Dr. Edward Patrick, West Chester, Penn.; Secretary, Dr. A. W. Colcord, Clairton, Penn.; Treasurer, Dr. E. H. James, Harrisburg, Penn.; Member of Executive Committee, Dr. Jos. M. Wells, Trenton, New Jersey.



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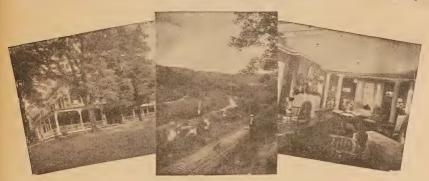
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# THE JOURNAL

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## COLLEGE OF PHYSICIANS AND RESERVED RESE BALTIMORE.

## PYELOCYSTITIS IN INFANCY.\*

BY EDGAR B. FRIEDENWALD, M. D., BALTIMORE, MD.

(From the Städtisches Kinderasyl in Berlin, Professor H. Finkelstein, Physician-in-Chief.)

The attention of the medical world was first called to the symptomcomplex, now generally known as pyelocystitis, by Escherich in 1894, under the title of colicystitis.

In the same year L. Emmett Holt 2 reported 3 similar cases, under the title of acute pyelitis. The comprehensive article of Finkelstein, and a little later that of Trumpp,4 first emphasized the frequency and importance of this condition.

Since then there have been numerous valuable contributions upon this subject, especially by Cnoff, Fromm, and Langstein in German, and

- \* Reprinted from Archives of Pediatrics, November, 1910.
- <sup>1</sup> "Mittheil. d. Vereins d. Aerzte Steiermark," No. 5, 1894.
- 2" Three Cases of Acute Pyelitis in Infancy," L. Emmett Holt, Archives of Pediatrics, November, 1894.
- <sup>8</sup> "Ueber Cystitis in Säuglingsalter," Finkelstein, J. K., XLIII, September,
- <sup>4</sup>Trumpp: Graz. "Versamml. d. Gesellschaft Deutscher Naturforscher u. Aerzte," September, 1896. . The see that
- <sup>5</sup> "Ein Kasuistischer Beitrag zur Lehre von der Bacteriurie," Cnoff, Münch. Med. Woch., No. 40, 1903.
- 6" Ueber Cystitis im Kindesalter," Eugene Fromm, Centralb. f. Kinderh., No. 10, 1904.
- "Bemerkungen zur Diagnose u. Behandlung der Cystitis u. Pyelitis im Kindesalter," Langstein, Therap. Monat., May, 1907.

Abt and Box in English, and finally the recent very comprehensive articles by Göppert, so that it will be impossible to give much that is new. However, on account of the abundance of hospital material observed, and particularly because of its bearing upon the etiology, pathology and treatment of this condition, I feel justified in presenting the following article.

The following study itemic of upon a series of 80 cases, derived from a large foundling hospitmonstris made up largely of young infants, many of whom suffer from the tonal disorders, and among whom infections, particularly grippe, and very common. The cases were very kindly placed at my disposal by Professor Finkelstein.

In this series I find 58 females and 22 males. This gives a percentage of  $27\frac{1}{2}$  for males, which is more than double the highest previously reported percentage of 11 by Göppert." The above statistics would tend to show that the disease is much more common among males than previously believed.

The youngest child in this series was eleven days, the oldest twenty-two months. Under one month there were 3; from one to three months, 25; from three to six months, 22; from six to nine months, 14; from nine to twelve months, 10; and over one year 6 cases.

Fifty-four cases occurred between the first of December and the first of June. The months of May, February and March had, respectively, 13, 11 and 10 cases, while June had none and October and November each 3.

The colon bacillus <sup>12</sup> is the common, exciting cause of this condition, and through it received the name under which it is best known, colicystitis. This organism was demonstrated in quite a number of this series. The proteus, <sup>13</sup> the pyocyaneus, <sup>14</sup> the subtilis, <sup>15</sup> the lactis aerogenes, <sup>16</sup> the tubercle, <sup>17</sup> and other bacteria have been described as causative factors.

<sup>&</sup>lt;sup>8</sup> "Urinary Infection in Children," Abt, Journal of American Medical Association, December 14, 1907.

<sup>&</sup>lt;sup>9</sup> "On Certain Bacterial Infections of the Urinary Tract in Children," Charles Box, *Lancet*, January 4, 1908.

<sup>&</sup>lt;sup>19</sup> (a) "Ueber die Eiterigen Erkrankungen der Harnwege im Kindesalter," F. Göppert, Ergeb. d. Inneren Med., u. Kinderh., Bd. II, S. 30.

<sup>(</sup>b) "Die Pyelocystitis des Kindesalters," F. Göppert. Berl. Klin. Woch., 1909, No. 14.

<sup>&</sup>lt;sup>11</sup> Previous reference.

<sup>12</sup> Escherich.

<sup>&</sup>lt;sup>18</sup> Baginsky, Lehrbuch d. Kinderhk.

<sup>&</sup>lt;sup>15</sup> Finkelstein.

<sup>16</sup> Escherich.

<sup>17</sup> Zelenski and Nitsch.

The proteus bacillus was found twice, the lactis aerogenes once in this series.

Zelenski and Nitsch <sup>18</sup> report 3 cases in which they were able to demonstrate the tubercle bacillus, both by slide preparation and also through animal experiment, as a cause of this condition. By what means does the infection reach the pelvices or bladder? The short urethra and its close proximity to the anal orifice in the female, form an easy passage for the bacillus coli to the bladder, especially if soft stools soil the vagina, <sup>19</sup> and readily explain the greater percentage of females afflicted.

That the infection can directly enter the urinary apparatus from the blood has been described by various authors.<sup>20</sup>

One other possible source of infection, described by Wreden, is a direct transmigration of the colon bacillus from a damaged intestine into the bladder. The question as to which of the above avenues forms the most probable entrance will have to be decided by careful culture experiments.

Any of the acute infections seems to act as a predisposing factor; also the severe nutritional disorders, probably in that they cause a general lowering of resistance. During the year ending February 1, 1910, there were 22 cases of pyelocystitis at this institution. One-half of these occurred in the months of November, December and January, during a severe epidemic of grippe.

Fifty-nine of our cases were directly preceded by either some infection or an acute nutritional disorder, while only 7 occurred under observation which were not preceded by a previous serious disorder. The 14 remaining cases entered with this condition, and while it is often not possible to get a previous history, we must assume that quite a number of these had also a definite predisposing factor. Twenty-one cases were preceded by some infection of the respiratory apparatus, of which 7 were grippe and 2 diphtheria; 12 others by otitis media, 7 by alimentary intoxication, 2 6 by septic conditions, 5 by enteritis follicularis, 4 by stomatitis, 2 by active syphilis with profuse eruption, and 1 each by tuberculosis and vaginitis.

<sup>&</sup>lt;sup>18</sup> Beitrag zur Etiologie der Cystitis bei Kindern, Przegladleharski, 1904, No. 1 (Polish).

<sup>19</sup> Escherich.

<sup>&</sup>lt;sup>20</sup> See previous reference, Finkelstein, J. K.

<sup>&</sup>lt;sup>21</sup> Zur Aetiol. der Cystitis. Centralb. f. Chirurg., 1893, No. 27.

<sup>&</sup>lt;sup>22</sup> Finkelstein's nomenclature (Cholera Infantum or Entero-Catarrh).

The 7 cases previously referred to must be considered primary, as they occurred while under careful observation at this institution, and showed absolutely nothing which might predispose to pyelocystitis.

Of 20 autopsies the kidney pelvices and bladder both showed pathologic changes in fifteen instances; three times the pelvices were alone involved, once the bladder alone, and in one instance there were no pathologic findings in the urinary apparatus, although the child had had pyuria six weeks previous to death.

That the lesion can be a simple catarrhal inflammation which quickly heals is shown in the following case where the patient, developing a pyelocystitis after an alimentary intoxication and dying seven weeks later of acute tuberculosis, gave no pathologic findings in either pelvices or bladder.

Case No. 58.—A. E., male of eleven months. Admitted July 13. Child had been in Asyl seven weeks and was given out into a family (Reconvalescenz Pflege) in improved condition, with good stools and weighing 5400 grams. It is returned in five days, weighing 4980 grams, very pale, depleted, hot, with glaring expression, and labored breathing. Urine gives albumen and sugar reactions, sediment negative. Child put on tea diet.<sup>23</sup> On the next day child's appearance is better, skin is dry, very little urine, pulse 160.

Diagnosis:

Alimentary Intoxication.—Two days later child had severe itching eczema, furunculosis, phimosis, glands of axilla and groin enlarged, weight 4700 grams. Urine: Sugar negative, albumen slightly positive, sediment contains pus cells and epithelium; pirquet positive; child gets urotropin 0.1 four times for a day, then three times daily 0.1 salol. In a week the urine becomes normal, and remains so upon repeated examinations until the end; salol is given for four weeks.

Six weeks after admission of child it becomes fretful and sensitive to touch, develops an acute tuberculous pneumonia from which it dies in about a week. Postmortem Findings:

Lungs.—Hepatization of left upper lobe, right upper lobe reddish, yellow infiltration; adhesive pleurisy on both sides.

Kidneys.—Slightly congested.

Spleen.—Enlarged.

Liver.—Very fatty.

Bladder.-Without abnormal findings.

The following case, in which patient died during an eclamptic convulsion, likewise gives the pathologic findings in a very mild case:

CASE No. 46.—C. M., female of one year, admitted April 5. A backward child, weight 5400 grams. Two weeks after admission child develops grippe, with vomiting, coryza and pharyngitis; has also a peritonsilar abscess a little

<sup>28</sup> A very weak tea flavored with saccharin.

later; alimentary decomposition <sup>24</sup> develops with a loss of weight in three days of 600 grams, thin and frequent stools, much vomiting and distended abdomen. Six weeks after admission urine shows slight albumin reaction, pus cells and hyaline casts; urotropin ordered. Four days later child develops severe tetany (spasmophilia) with laryngospasm, Chvostek's phenomenon and K. O. Z. under I. Child dies two weeks later during an eclamptic attack.

Postmortem Findings:

Heart.—Somewhat enlarged, especially left ventricle.

Bladder .- Injected.

Organs.—Otherwise show no change.

In the 2 following cases, one with death from uremia, the other from colimeningitis, the lesions of acute pyelocystitis are well shown:

Case No. 7.—A. W., female, age eleven days, admitted May 22. A restless child, with gray-yellow septic appearance, mouth red, umbilicus secreting, empties pus on pressure, sound passes 1 cm. into umbilicus, stools bloody and contain much mucus, incoordinate movements. Child alternates between low moaning and loud screaming. Three days later, movements sluggish, mouth red, child drinks very poorly.

Urine.—Color somewhat icteric, albumin positive, slight reduction of Fehling's sediment contains bile, salt crystals, numerous red blood cells, pus cells and granulated casts. Three days later child vomits, is still somewhat soporous. Two days later condition is improved; color good; small phlegmonous infiltrations on abdomen, umbilicus does not secrete, child cries vigorously, seems to have severe colic. Urine contains numerous pus and red blood cells. In afternoon, spasm of eye muscles and extremities, child means much, Cheyne-Stokes respiration, somnolent condition, protrusion of fontanel.

Spinal puncture gives a purulent fluid, in smear many leucocytes and diplococci.

Next day, slight opisthotonus, no palsy or spasm of extremities, fontanel tense and protruding. Spinal puncture gives cloudy fluid, a culture of which shows coli and diplococci.

Urine.—Dark, bloody, albumin positive; in sediment numerous red blood and pus cells and bacteria; granulated hyaline and bacterial casts.

Breathing irregular, pulse accelerated, spasm of eye muscles and extensor spasm of extremities. Phlegmon on abdomen, right kidney larger than left.

Next day, meningitis progresses slowly, subjectively some improvement. Child cries as soon as one touches it, somewhat somnolent, no opisthotonus, urine unchanged.

Following day, vasomotor irritation, gray skin color, phlegmon in abdomen necrotic, umbilicus secretes a sanguineous fluid, frequent bloody vomiting. Spinal puncture gives bloody, viscid, purulent fluid. Urine the same, child going down hill, dies June 1.

Postmortem Findings:

The umbilical arteries are blocked with pus for a distance of 5 or 6 cm., pus cavity beneath umbilicus, peritoneum intact.

Right kidney somewhat congested, no noticeable nephritis, very severe purulent meningitis, especially at base in region of foramen magnum.

Bladder hemorrhagic and swollen.

<sup>&</sup>lt;sup>24</sup> Finkelstein's Nomenclature. (Acute Infantile Atrophy or Marasmus.)

Case No. 24.—K., very young female. Admitted June 30. A marasmic, apathetic child, very pale, with dry skin. Fontanel depressed, lips dry, cervical glands lentil size, lungs normal, abdomen also.

Two days after admission child in somnolent condition, severe vomiting, dyspeptic stools. Five days later condition unchanged, furuncle on head. On following day child quite weak, slight tremor, transitory erythema; next day weaker, some opisthotonus, spleen not palpable. Next day fontanel much depressed, bulging of both ear drums, convulsions of arms and legs, cataleptic in character. Paracentesis. Two days later, opisthotonus continued, râles over right lung, no vomiting. Urine contains albumin and pus cells, but no casts.

A progressive uremic condition follows, from which patient dies after three days.

#### Postmortem Findings:

Lungs.—Bronchitis. Kidneys.—Slightly opaque. Pelvices.—Engorged and turbid, in right one linseed-size concretion. Bladder.—Mucosa loose and swollen, in neck small concretion.

In cases in which the proteus bacillus was the exciting cause, the inflammatory condition went on to the stage of local necrosis, giving the appearance of a diphtheritic affection.

Case No. 6. M. P., female of four months. Admitted April 28. A very marasmic, emaciated baby, pale cyanotic appearance, bulbar atrophy, chicken breast, numerous petechial hemorrhages over body, glands not palpable; spleen, palpable; abdomen sunken in, heart sound normal, some râles over lungs.

Next day, stools hemorrhagic, contain much pus and mucus; blood culture negative; child in state of severe collapse.

Two days later, opisthotonus, stools unchanged.

Next day, urine taken with catheter is cloudy, thick, purulent, malodorous, and of alkaline reaction; in sediment are numerous pus cells and bacteria; culture shows proteus, liquefying gelatin, no streptococci. Culture from blood of saphenus vein and of spinal fluid negative. Clinically, the case is of interest by the appearance of numerous petechiæ, which are also produced by rubbing or exerting pressure on skin.

#### Postmortem Findings:

Brownish-green discoloration of bladder mucosa, with numerous punctiform hemorrhages and dirty purulent deposits.

The pelvices of kidneys filled with dirty, brownish pus; papillæ on both sides covered with dirty deposits; kidneys moderately enlarged and show punctiform hemorrhages.

Case No. 9.—E. S., female, age four months, admitted February 15. A moderately developed twin child. Other twin born with rash, and died shortly after birth. This baby, bottle-fed, fourteen days after birth developed coryza and rash, also green stools. Child shows desquamative erythema on trunk and face, xerosis and ulcus cornea, deep fissures at mouth and anus, fever, appearance slightly cyanotic, extremities cold, several furuncles on the extremities; glands not enlarged; kidneys not enlarged; stools thin and slimy. Urine, hemorrhagic appearance, contains some albumen, numerous pus cells,

clumps of bacteria, no kidney elements; a culture shows proteus liquefying gelatin, also scanty growth of bacillus coli. Two days after admission profuse mucopurulent secretion from nose, furuncle on head, passes very little urine, bleeding fissures at anus.

Urine.—Reaction acid, much albumen, many pus cells, bladder epithelium, tailed epithelium, clumps of bacteria. Five days later, liver large and hard, good stools, gradual weakening and death after three days.

#### Postmortem Findings:

Bronchopneumonia, hemorrhagic foci in lower lobes of both lungs. Liver fatty and of orange color. Bladder in trigonum blackish-green, necrotic discoloration, out of which some light yellow, purulent tissue projects.

Both kidneys about one and one-half times normal size, relaxed, yellow-red color, capsule easily stripped off, spotted hemorrhagic surface, showing some white, necrotic foci of pin-head size. Cut surface moist and swollen, cortex enlarged, pyramids reddened and inflamed, pelvices markedly congested, with profuse punctiform hemorrhages; spleen not enlarged.

The following led rapidly into acute parenchymatous nephritis:

Case No. 2.—H. K., female, six months of age, admitted May 2. A well-nourished child, has had suppuration of nose for four weeks, is apathetic, cyanotic and pale, has poor appetite, twitching of arms, accelerated respiration; pulse 144, temperature 39. Border of nose is excoriated, and there are some linseed-size ulcerations on face, throat is red, over both lungs some rhonchi are heard, left kidney seems enlarged; stools dyspeptic; urine, much albumin, many pus cells, some cubical and tailed epithelium, epithelial casts. Child develops stomatitis and pharyngitis, breathing becomes labored, has no appetite, kidneys become enlarged, there is a tremor of the hands.

Child becomes weaker and weaker, and dies five days after admission.

#### Postmortem Findings:

Severe swelling and redness of bladder mucosa, with many extravasations of blood, both kidneys are large, soft, with serous infiltrations and parenchymatous cloudiness, the pelvices are slightly injected, slight bronchitis, no tuberculosis.

Case No. 4.—H. K., female, age six weeks. Admitted July 6. An amaciated, small child, did not receive breast, was profusely nourished and became gradually emaciated. Child cries much, passes large quantities of urine, has diarrhea and vomits. Last night had convulsions. Child has glaring look, abdomen is tympanitic, otherwise no findings. Stool yellow-green; urine, acid, colorless, reduces Fehling's. Two days later urine findings same, except reduction is less marked. Child has rice soup stools; temperature 38° C. Six days later urine contains many pus cells, some tailed epithelium, and masses of motile bacilli. Child becomes weaker and weaker, and dies two weeks after admission.

Treatment.—Irrigation of bladder with solution of silver nitrate.

## Postmortem Findings:

Lungs.—Some atelectasis.

Bladder.—Mucosa slightly dilated, with red spots, especially at openings of ureters.

Gray spots in neck of bladder and slight pigmentation in fundus, kidneys, softened, pelvis slightly injected and gray-red.

CASE No. 44.—M. K., male, newborn, admitted January 25. A fine child, weighing 3170 grams; when two weeks old child has dyspepsia 25 and stomatitis. One week later child very restless, cries much. Urine contains albumin and many pus cells. Urotropin, 0.2, four times daily, ordered.

Five days later child marasmic, has slight jaundice.

Urine findings continue same. Child gradually goes down hill, dying two months after birth.

## Postmortem Findings:

Kidneys are enlarged, dark red, appearance spotted; parenchymæ opaque; yellowish-white nodules in cortices and medullæ; pelvices engorged. Bladder without abnormal findings.

That tendency to septic nephritis and abscesses of kidney are not at all uncommon is shown by the following cases:

CASE No. 8.—G. Q., male, two months of age. Admitted April 13. Weakly child, has been sick five days, skin, mucous membranes and conjunctivæ are slightly jaundiced; child is somewhat soporous, drinks poorly, and lies mostly with his mouth open; there is marked opisthotonus, mild spasm of extremities; reflexes, however, are not increased. Voice is clear, eyes bright, mouth clean, spleen not enlarged, kidneys palpable and somewhat enlarged, fontanel not protruding, liver overlaps costal arch three fingers' breadth, pulse very slow, breathing very slow and irregular, no hyperesthesia, fundi of eyes normal, stool slimy and broken up, no micturition. After ingestion of food, vomiting, even after tea. Next day, high fever, child restless and moaning; there is slight erythema on breast and face. Soporous condition continues, also vomiting, jaundice becomes more pronounced, hemorrhagic fissures appear on flexor portion of knees and roseolæ are noticed on abdomen and on thighs; spleen not palpable; no micturition, no movement of bowel. From spinal puncture clear fluid obtained under normal pressure. Child dies on following day.

#### Postmortem Findings:

Both sides pyelonephritis with copious miliary and larger abscesses, catarrhal cystitis, cloudy swelling of liver.

Case No. 14.—J. K., female, age seven months, admitted February 14. Nutritional condition good, good tonus, skin slightly cyanotic and of remarkably livid appearance, accelerated respiration, nostril breathing, pulse regular and frequent; on trunk and extremities several blue spots, also on face; marble-like appearance of cheeks, some opisthotonus, high fever; child very restless, moans much, and is slightly soporous.

Urine.—Reaction acid, much albumin, many pus cells, no sugar.

Two days later, numerous petechiæ on upper extremities, fontanel somewhat tense, some opisthotonus, labored breathing, urine same, but also some red blood cells.

Following day, condition growing worse, great weakness, slightly soporous, accelerated breathing, distended abdomen; spinal puncture, no findings; blood culture shows colon bacillus, also culture from catheterized urine shows some.

Following day, moans much, breathing labored, anxious expression, heart sounds very low, heart dullness increased.

<sup>25</sup> Finkelstein's nomenclature (intestinal indigestion).

## Postmortem Findings:

Lungs normal, heart double the size of a fist, right ventricle dilated. Large, congested kidneys, on surface alternating light-yellow and reddened spots. In cortex many abscesses, parenchyma cloudy and swollen; in right kidney hemorrhagic infiltration of hazel-nut size. Pelvic mucosa slightly reddened, bladder unchanged.

Case No. 18.—I. B., female, age eight and one-half months, admitted January 1. Bottle baby, sickened with fever and convulsion three days ago. Very lively child, craniotabes, all organs normal, throat somewhat reddened. Day after admission has high fever, throat more severely inflamed, on back and abdomen rather diffuse erythema; stools soft, general findings good. Next day, face pale, scarlet coloration of neck and breast. Following day, spleen palpable, volatile erythema; stool contains much mucus and microscopically much pus and epithelium.

On the following day ear drum on right side somewhat reddened, without lustre and bulging; stool contains some blood.

Day later, appetite bad, child cries on being touched; stools thin and slimy; cloudy urine which contains trace of albumin, pus cells, bladder epithelium and masses of bacteria.

Two days later child marasmic, tremor of lower jaw, faint appearance (the condition simulates either typhoid or meningitis). The mucus of stool shows many pus cells and coli-like bacteria. Beginning otitis media. Next day child cries with strong voice. Following day slight opisthotonus, drinks badly. Next day child does not drink, lies quietly with head back, knees flexed; over both lungs light rhonchi, lips dry. Urine taken with catheter. Child cries much at night, no vomiting, no convulsions, abdomen distended. Two days afterward child drinks well; lively appearance. Two days later, great collapse and exitus.

## Postmortem Findings:

Spleen normal size, soft. Liver large and spotted. Atelectasis of lungs. Stomach and intestines swollen, injected and inflamed. Kidneys are more than three times enlarged, soft, spotted, with red and yellow portions, capsule easily stripped off. On the surfaces many yellow hemorrhagic spots, cortices widened. In cortical substance many abscesses with tenacious pus, also in medullæ and near papillæ. In pelvices hemorrhagic spots. Bladder mucosa swollen and congested, with many lentil-size hemorrhagic spots. From urine, intestines, blood, and organs cultures show bacillus lactic aerogenes.

CASE No. 22.—G. J., female, age three months, admitted January 9. Small child, sent in on account of intertrigo and eczema.

Two days later patient lies with retroflexed head, no edema, slight cranic-tabes, coryza, maxillary, axillary and inguinal glands somewhat enlarged. Eczema on back, blisters filled with pus on left heel. Kidneys palpable, dyspeptic stools, both ears secrete pus.

Twelve days after this, large furuncle in Achilles region of left limb.

Two weeks later child somewhat improved, right ear still runs.

Two days later child worse, stools dyspeptic. Three days later urine contains much albumin, pus cells, hyalin and granular casts. Child gradually sinks and dies in a few days.

## Postmortem Findings:

Bronchoppeumonic foci in both lungs, liver enlarged, kidneys enlarged,

parenchymatous nephritis, obliteration in cortex with sparse abscesses. Pelvices and bladder congested and engorged.

CASE No. 80.-L. B., female, two months old, admitted May 3.

A day before admission the patient developed severe collapse, with very rapid pulse and cyanosis. The bladder extended nearly to the umbilicus. Through catheterization 100 ccm. of a very cloudy urine was emptied. The reaction was alkaline, the sediment contained pus cells. After the administration of camphor there was some improvement; the child, however, collapses repeatedly with asphyxia and cyanosis after taking tea, and also independently of the ingestion of food.

On day of admission the child was lying unconscious with head flexed. It reacts upon pinching by moaning anxiously. The legs were flexed, skin was cyanotic and gray, respirations were flat, heart and lung sounds normal. The bladder was palpable to midway between the symphysis and umbilicus; the right kidney was more easily palpable than the left.

On next day child is somewhat better, there is still opisthotonus. It cries much, micturates three times during night, but bladder still palpable as before.

On next day child cries upon being touched, bladder as before, right ear secretes profusely. Catheterization yields 100 ccm. of urine; bed-sore in sacral region.

Next day opisthotonus very pronounced, other findings as before.

Following day child very weak, stools thin, child sinks, exitus follows next day.

## Postmortem Findings:

Both kidneys greatly enlarged, the right more than the left, the capsules are loose. Cortices much engorged and contain numerous small abscesses of pin-head size. Pelvices dilated. Bladder wall much thickened, with rough and injected mucosa. Urethra normal. Even by severe pressure on the bladder no urine can be emptied.

CASE No. 23.—M. B., female, age seven months, admitted April 27. An emaciated, pale child, has had diarrhea, vomiting and coughing for the past two weeks. Child has rickety rosary, rhonchi over both lungs, greenish-brown dyspeptic stools.

Three days later many râles heard over both lungs. Three days after this, child in somnolent condition, coughs much, lung signs less marked. Urine reaction acid, no albumin, contains mucin and urates.

Two days later child is lively, stools remain dyspeptic for a week, then urine becomes cloudy, shows traces of albumin, many pus cells and bacterial clumps. Salol ordered.

Next day, patient very weak. Irrigations of bladder with lysol. A week later kidneys not enlarged, urine same as before, appetite bad, dyspeptic stools. Irrigations continued.

Two days later left ear and also kidney region painful on pressure. Progressive weakening and great loss of weight, with exitus after three days.

## Postmortem Findings:

Bladder greatly swollen and engorged, particularly in fundus; pelvices of kidney congested. Kidneys large, relaxed and pale-red. In cortices and pyramids many abscesses, catarrhal engorgement of bowel, follicles engorged and ulcerating foci. Bacterium coli grown from urine.

CASE No. 29.—E. P., male, age nine months, admitted February 16. Small child, under weight, has had fever, vomiting and bad stools for a long time. Urine contains albumin and much pus; furuncles on neck.

Next day child vomits, both ear drums reddened. Two days later continuous vomiting, rapid loss of weight, double otitis media. After four days patient pale and thin, urine reaction acid, turbid, some albumin, many pus cells; kidney epithelium, no casts. Three days later kidneys palpable and enlarged, gradual weakening and death after two days.

## Postmortem Findings:

Kidneys show nephritis with cortical abscesses, the pelvices are severely inflamed, bladder only slightly congested.

CASE No. 34.—E. K., male, age six weeks, admitted June 20. A slightly debilitated bottle baby, has been coughing and hoarse for past week, vomits since birth. Child is slightly cyanotic, cries much, hands and feet cold, intertrigo adnates, slight hoarseness, abdomen somewhat tense, spleen and kidneys not palpable.

Three days later, still somewhat hoarse, stools broken up and green, some blood. Three days after this sleeps much, vomits much, dyspeptic stools; two days later some coughing. Next day child laughs, no temperature, stools better.

After a week child is quiet, slight cyanosis, marasmic. Two days later crepitant râles over lungs, coughs, slimy stools; temperature 38.5° C. After three days patient declining, bad stools. Two days later patient quiet, looks very bad; temperature 39.4° C. Urine turbid, many pus cells, bladder and tailed epithelium, few granular casts, urotropin ordered. Two days later, breathing rapid, pulse small and rapid, dyspeptic stools. Next day right ear drum distended; temperature 39.5° C.; stool contains pus, urine the same. After a week child is very marasmic, dyspnea, vomiting, abdomen sunken in, skin gray-yellow, but no jaundice. Exitus.

## Postmortem Findings:

Kidneys much enlarged, congested surface, spotted with small hemorrhages. On cross section deeply red and congested, spotted streaks of pus in pyramids. Pelvices, thick fibrinous pus. Bladder hardly changed.

The condition may become chronic, forming permanent changes, as is shown nicely by these cases:

CASE No. 1.—E. S., female, age three months, admitted May 14. A well nourished and developed child is admitted with general luetic eruption, snuffles, alopecia of eyebrows, enlarged glands, and enlarged liver and spleen; temperature normal.

Six days after admission child develops temperature of 39° C., drinks badly, and is markedly pale. The urine shows albumin, many pus cells and bladder epithelium; also many bacteria, which upon culture proved to be bacillus coli. There is little change in the child's condition for about ten days, then it becomes restless, limbs become slightly edematous, kidneys become somewhat enlarged, and urine shows, besides previous findings, some red blood cells, hyalin, pus and bacterial casts. Child's condition gradually grows worse; becomes weaker, anemic, loses weight, kidneys are distinctly palpable and hard; a distinct friction is felt over spleen.

After nearly six weeks' illness child gradually sinks, develops a cholera-like uremia with diarrhea and vomiting, and dies suddenly in collapse.

Treatment.—Urotropin and bladder irrigations of boric acid and silver nitrate solution every other day.

## Postmortem Findings:

Mucosa of bladder and of kidney pelvices thickened and congested. Both kidneys are large, yellow and soft, and show numerous hemorrhagic foci of linseed size, cloudy swelling of parenchyma; spleen large with thick, fibrinous coating.

Case No. 16.—M. G., female, age one year and one-half, admitted July 28. Child markedly under weight and slight rachitis, tonsils enlarged, abdomen slightly distended, drinks well.

Four days later child developed severe pharyngitis; one week later urine contains pus cells. 0.2 urotropin three times a day. After three days child has laryngospasm.

Temperature normal three weeks, child cries much, kidneys apparently very tender, left kidney palpable; urine cloudy, albumin, many pus cells.

Day before yesterday many granulated casts were found; these are not present to-day.

After two days urotropin discontinued, salol, 0.1, three times a day, ordered. Five days later child more lively; urine clear, but contains many pus cells; no casts.

After one week, child is still very pale, distressed, vomits and cries very much; over lungs profuse rhonchi, behind sternocleido small glands; kidneys palpable, urine contains much albumin, few pus cells.

Two weeks later continued bad condition, waxy appearance, anxious expression, face puffy, eats poorly, vomits much, abdomen tense, kidneys very tender; urine, amphoteric reaction, much albumin, few pus cells. Next day child develops clonic spasms, lasting half an hour. Child becomes comatose, vomits much, face distinctly puffy, no edema on body, heart action becomes irregular, pulse cannot be felt; venesection, saline infusion. Child collapses and dies following night.

#### Postmortem Findings:

Heart size of child's fist. Ventricle somewhat dilated; lungs, passive hyperemia; spleen, normal; liver, normal; pancreas without findings. Left kidney soft, of gray-yellow color; capsule easily stripped off; surface shows fine granulations, also many linseed-size cysts. Medulla mostly gray-yellow, only a small portions shows dark-blue discoloration. The cortex and medulla not to be distinguished from one another in most places.

The blue-red discolorations appear as islands in medulla; the pelvic mucosa shows fine granulations at various points. Right kidney, soft capsule easily removed and not thickened, the surface granulations are crossed by numerous red striæ. Cysts not as numerous as in other kidney, but somewhat larger. On cross section the medullary portion shows bluish-red configurations, which shade off into gray-yellow cortex. Pelvis somewhat distended and shows granulations. Ureters on both sides red, swollen and somewhat distended.

Bladder mucosa moderately folded; on the tops of folds mucous membrane is gray-yellow, in deeper parts red. Many pin-head size hemorrhages in mucous membrane, vessels injected.

From the above we see that while this condition may only be a simple catarrhal one, readily healing under proper treatment, it may, on the

other hand, be very severe and lead rapidly into either acute parenchymatous nephritis or pyelonephrosis, or may become chronic. The relation of this condition to kidney lesions is very close and practically all severe cases show at least kidney irritation, as is observed by the common presence of casts in the urine of cases of pyelocystitis. We would also like again to refer to Cases 7 and 24 in this regard.

Clinically, we distinguish two forms—the one mild, the other severe. We must, however, remember that these forms have various degrees of severity and also blend into one another.

In the mild form we find an elevation of temperature, some loss of appetite, some unrest, possibly vomiting and a peculiar pale appearance. The urine will usually show an acid reaction, some slight cloudiness, some albumin, while the sediment contains usually pus cells, bacterial clumps and some cubital or tailed epithelium. The temperature may only reach 37.7° C., or it may go somewhat higher. A tendency to higher temperatures is especially noticed in exudative diathetic children. Any or all of the symptoms may be wanting in this form, and our first attention to this condition may be called by the findings of a urinary examination.

CASE No. 28.—G. B., female, age three weeks, admitted August 23. Small, moderately developed child, with slight conjunctivitis; no rash, glands not palpable, organs normal, weight 2850 grams. Child is nourished on the breast and progresses nicely with normal temperature until December 1. At this time bottle is added, weight 3800 grams. During the middle of this month child develops coryza, pharyngitis and bronchitis, with temperature, which, however, passes off rapidly and child develops nicely; gains in weight until the end of March, when the weight is 6200 grams. Beginning of April child drinks badly, loses weight, has a pale, distressed appearance. The urine is turbid and contains many pus cells. Salol, 0.1, three times a day, is ordered. Child runs temperature and urine remains unchanged for a number of days. On the ninth of April condition is much improved, but there are still albumin and pus cells in urine. A little over three weeks after the commencement of this condition the general condition of child is good; urine is clear and remains so. Child is dismissed the first of May in good condition, weighing 6140 grams.

Case No. 49.—Female, age three months, admitted September 10. Small, well-nourished child, skin color good, mouth, throat, navel, heart, lungs, are all normal. Abdominal walls round and soft; liver and spleen not palpable; no signs of lues. Child has bronchopneumonia in October, from which is recovers nicely.

During an epidemic of grippe toward the latter part of November child develops this condition with coryza, cough and bronchitis. On December 11 temperature gradually rises, and on the 15th child drinks badly and pus cells are found in urine. Salol, 0.2, four times a day, is ordered.

Child is again drinking well the early part of January; urine is without abnormal findings, and salol is discontinued. Child later on develops otitis media, bronchitis and pharyngitis, from all of which it make a good recovery. During all this time urine remains perfectly normal. Child is dismissed in good condition the first of March.

Case No. 53.—A. S., female, age three weeks, admitted January 16. Father and mother healthy, delivery normal. A slight, lively, breast-fed infant of good color, all organs normal, weight 2700 grams.

Two weeks later child runs slight temperature without symptoms; weight 2900 grams. Catheterized urine shows in sediment, masses of pus cells; urotropin, 0.1, four times a day, is ordered. One week later weight 3020 grams, and urine gives no abnormal findings. Child is dismissed on February 10 with weight of 3100 grams and normal urine.

Cases of this type rarely last over two weeks and are usually much shorter in duration.

The severe type of this condition is characterized by an increase of the severity of the individual symptom mentioned under the mild type, plus other and more grave symptoms. The temperature is higher and usually lasts longer, and may either be intermittent, remittent or continuous. It may subside by lysis or crisis.

In one very severe case the temperature was always subnormal, never reaching normal.

There is often much restlessness and agitation which not infrequently alternate with periods of listlessness and quiet. The loss of appetite is very prominent; this may go to the absolute refusal of any liquid.

Probably the water hunger, owing to this, gives the most characteristic picture. The paleness is more marked and the patient lies with eyes wide open and an anxious expression; they are very susceptible to touch; vomiting is usually present, and stools are generally dyspeptic. The breathing is rapid, but superficial, the pulse rapid; opisthotonus is often present, sometimes very marked. In the more severe cases jaundice is not uncommon, nor the presence of edema; there is also a tendency to hemorrhages, especially to petechiæ. Tremors and convulsions may develop; the patient often becomes soporous and even comatose. The onset is usually very sudden in this form, the kidneys usually become enlarged, palpable and tender on pressure. Shaking chills have also been noticed. The urine is the same as in the mild form, with the addition also of various forms of casts and sometimes of red blood cells. Various combinations of these symptoms form symptom-complexes which closely resemble, and which may be mistaken for, other diseases. We would like

to refer again to Cases No. 4 and No. 8, and call attention to the following as examples of this form:

Case No. 32.—E. H., male, age four months, admitted August 3. An emaciated and anemic child, weight 3200 grams, ears sensitive to touch, both ears discharging, otherwise no findings. One week later child becomes very restless, appears faint and weak, drinks very poorly, stools dyspeptic, ears discharge freely; urine contains many pus cells; salol, 0.1, three times a day, ordered.

One week later small petechiæ are noticed on face and abdominal wall; still drinks very poorly. Four days later weight 3080 grams, condition good, stool good, drinks well. Child gradually gains in weight until one month after the development of pyelocystitis; the urine finally becomes free of all morphologic structures, condition is good, weight 3670 grams. Salol is discontinued. One month later weight 4200 grams, conditions good, urine does not show abnormal findings; dismissed.

Case No. 51.—P. S., male, age ten days, admitted October 19. Normal delivery, parents healthy, received breast until yesterday. Pretty child, somewhat under weight, jaundice, navel moist, mouth, lungs and other organs normal; nothing for lues; weight 2800 grams. Child progresses nicely and without incident, gaining in weight. The end of December child develops a coryza, with bloody secretion, which proves to be diphtheria.

A week later child has serum exanthema. A few days later child drinks poorly, vomits, has dyspeptic stools, is pale, and urine contains pus cells; salol, 0.2, four times a day, ordered. Urine clears up slowly; temperature gradually falls. End of February child has otitis media, urine gives no abnormal findings. Child is dismissed middle of March in good condition.

Case No. 65.—H., female, age twenty-two months, admitted October 14. Weakly child, no disease preceding, sickened suddenly with fever, restless condition, poor appetite. Only some days later can urine be procured. It contains typical sediment, trace of albumin, no casts, acid reaction. Child has considerable tenesmus.

Treatment is commenced on eighth day of illness. Salol, 0.15, three times a day. Two days afterward urine cleared up; on 20th temperature sinks by crisis, urine becomes normal. Cured.

The course in this form usually runs from about ten days to three or four weeks, but may last many weeks or months. There is a tendency to relapses, both in the mild and severe type, and relapses may, at any time, give a graver symptom-complex than the original attack. The case following is an example of a moderately severe pyelocystitis, with tendency to relapses.

Case No. 52.—H. B., male, age two and one-half weeks, admitted November 30. Well-nourished child, skin much reddened and some desquamation on abdomen, severe intertrigo on neck and between thighs, foot-soles red, and some desquamation on left one, desquamation on head, no glands palpable, the liver and spleen not enlarged, heart and lungs normal, also pharynx. Aphthous stomatitis on front border of the lower gum; temperature normal,

weight 3900 grams, exudative diathesis. December 2 child lies in comatose condition, looks very septic, dyspeptic stools. December 3 urine cloudy, no sugar, trace of albumin; sediment contains masses of pus cells, few hyalin and granular casts. Salol, 0.1, four times a day, ordered. December 7 urine still contains many pus cells. December 17 salol discontinued. December 21 urine contains few pus cells and epithelium. December 29 urine clear, no abnormal findings. January 8 temperature, many granular casts, epithelium and pus cells in urine. Salol ordered again. January 19 urine without findings. Salol discontinued. January 28 urine without findings. Child discharged in good condition on March 3.

While the mild form occurs often, with so few symptoms as to be entirely overlooked without a urinary examination, the severe form at times resembles very closely other severe conditions. With marked toxic symptoms, this disease is at times very like an alimentary intoxication; with cough and nostril breathing we may think of a pneumonia; with opisthotonus, tremors and disturbances of consciousness the picture is not unlike meningitis; with an intermittent temperature, and particularly where there are shaking chills, malaria may be thought of; and, finally, the paleness, quietness, listlessness, and susceptibility to touch may remind very forcibly of Morbus Barlow. A careful urinary examination will always clear up any doubt and assure the diagnosis.

The mild type, as a rule, yields readily to treatment, and clears up in a very short space. In fact, there are probably a number of cases of this form that are not diagnosed and heal spontaneously.

Far different, however, is it in the severe form; here the prognosis is always questionable. On the one hand, quite a number of cases lead rapidly into fatal nephritides, some to sepsis; while, on the other hand, the not fatal cases show a marked tendency to recurrences and there are some cases which become chronic, yield to absolutely no treatment and continue with pyuria for months and years.

I would like to mention in this respect the following:

Case No. 70.—E. L., a boy baby of two months, in whom a moderately severe pyelocystitis developed last September, after a stomatitis, and although child received over long periods salol, urotropin, sodium bicarbonate and combinations of these, and although child's general condition remained good, there has been, until this time, a continuous pyuria, absolutely unyielding to our treatment.

The two indications in treatment, so clearly described by Göppert,<sup>26</sup> are the bringing of water into the system and the giving of certain urinary antiseptics.

<sup>26</sup> See previous reference.

The flushing of the urinary apparatus and the overcoming of the water hunger, if the child will drink large quantities of water, can be accomplished readily. However, this is often not the case, and we must either use for this purpose the stomach tube, as advised by Göppert, or, as preferred at this institution, the giving of rectal enemata of Ringer's solution by the drop method, as described by Rosenstein for pylorospasm. Marked improvement nearly always follows this procedure. The medicament found most reliable at this institution is unquestionably salol in doses of 0.1 to 0.2 three to four times daily.

In only 2 cases where this did not prove satisfactory did urotropin give better results, while salol had to be substituted for urotropin numerous times before results were obtained.

The 2 following cases are of interest in regard to treatment:

Case No. 61.—F. O., male, age one month. August 8 developed suddenly a very severe pyelocystitis without any predisposing cause, he having been under careful observation. The very threatening symptoms yielded nicely to rectal instillations, but a chronic pyuria with varying temperatures continued until December 1. The urine, which at first was acid, became alkaline and remained so. Salol was given almost continuously during this period. Within ten days after the substitution of urotropin, 0.25, three times a day, the urine cleared up, temperature became better and color gradually improved. Child made an uneventful recovery.

Case No. 50.—R. K., male, age five months, admitted December 16. Rather weakly child, coughs, pharynx and tonsils inflamed (pharyngitis), lungs normal, no palpable glands, spleen not palpable, no sign of lues, dyspeptic stools. December 17, pharyngitis, stool good; December 20, pharyngitis continues, stool good; December 23, child drinks poorly, urine cloudy, albumin positive, many pus cells. Salol, 0.2, three times a day, ordered. January 2, few dry rhonchi over lungs, abdomen much distended, dyspeptic stool, pulse 144; January 10, condition of urine same as before; albumin, many pus cells, bacilli, no casts. Salol discontinued; urotropin, 0.25, four times a day, ordered. January 24, condition of urine unchanged, bicarbonate of soda added. March 13, urine has at last cleared up, gives no abnormal findings and remains so. Child dismissed on March 17.

From the fact that we consider the condition nearly always a pyelocystitis, and also from lack of results at this institution by irrigations, we cannot recommend irrigations of the bladder. Until now, serum treatment in children has not proved satisfactory, according to the reports of several authors.

In closing, we wish to emphasize the commonness of this condition, not

<sup>&</sup>lt;sup>27</sup> "Rektalinstillationen bei Pylorospasmus," J. Rosenstein. Deutsche Med. Woch., No. 1, 1910.

only in female infants, but also in males; that both the bladder and pelvices of the kidney are usually involved, and, finally, that the systematic examination of the urine of infants is not only necessary, but will, in many instances, relieve the physician of much doubt and worry and lead to the relief of much suffering in many babies and also to the saving of many lives.

## HAGERSTOWN, MD., April 13, 1911.

My dear Doctor.—It is the wish of quite a number of our class of '75 of the C. P. & S. to hold a class reunion in Baltimore, at the time of the College Commencement, which will be June 6. I, with others of the class, would like to meet you once again. I am adding a list of all left of our class, so far as I know. I suggest as Chairman of this reunion Dr. J. D. Blake of Baltimore. I am writing to every one of the class and hope you will write and tell me what you think of the plan.

With best wishes and hoping that you will meet with us, I am Very truly yours,

L. H. Keller.

Albaugh, Eugene R., Glenville, Pa. Belville, Frank, Delaware City, Del.

Blake, Jno. D., 1014 Lafayette Ave., Baltimore, Md.

Crow, A. W., Livermore, Ky.

Hyson, J. Miller, Red Lion, Pa. Keller, Luther H., Hagerstown,

Md.

Latimer, J. W., Galena, Md.

Micheau, Ellis, 504 N. Fulton

Person, J. E., Pikeville, N. C.

Ave., Baltimore, Md.

Pinnix, J. A., Tony, N. C.

Newbill, C. F., Center Cross, Va. Saulsbury, Theodore, Burrsville,

Md.

Stafford, C. E., Eggleston, Va.

Vance, C. S., Cisco, Texas.

Wiley, J. K., 724 N. Carey St., Baltimore, Md.

Walling, Byron W., Poolesville, Md.

Wiley, Chas., 812 Pennsylvania Ave., Pittsburg, Pa.

JERSEY CITY, N. J., October 3, 1910.

Dear Dr. Brack.—Enclosed please find check for Alumni Journal for 1910 and 1911. Hoping you are enjoying good health and your share of the good world's happiness, I am, Fraternally yours,

FERDINAND N. SAUER.

# THE JOURNAL

## OF THE ALUMNI ASSOCIATION

OF THE

## COLLEGE OF PHYSICIANS AND SURGEONS,

## BALTIMORE.

# AN APPEAL TO THE ALUMNI OF THE COLLEGE OF PHYSICIANS AND SURGEONS.

The advantage and the necessity of up-to-date hospital facilities and equipment in conjunction with medical teaching is fully recognized by the medical man of to-day.

The College of Physicians and Surgeons has been exceptionally fortunate in having associated with it for many years and in having the medical and surgical control of the City Hospital, or rather the Mercy Hospital, which is conducted by the Sisters of Mercy.

It has been found expedient and necessary to enlarge these hospital facilities and two new buildings, one of which is to be a maternity and nurses' home, are in the process of construction at a cost of \$300,000. One building is now nearing completion.

Such an enterprise cannot be conducted without substantial assistance by the general public and by our friends and associates.

We feel that our Alumni should be closely identified with this undertaking, which will greatly add to the prestige of our college and afford us facilities, which will place us in the front rank of the unendowed medical schools of the United States.

Every one of us can be proud of his Alma Mater and of his diploma from the College of Physicians and Surgeons.

The standing of our school is among the first and with our present up-to-date laboratory equipments and the added hospital facilities the practical instruction in medicine and surgery in our school will be unexcelled. We appeal to you, therefore, to contribute as liberally as you can to this worthy undertaking.

The suggestion has been made that such contributions from our

Alumni be more closely defined by being applied, not to the cost of erection of the buildings, but to the equipment of the hospital. Certain wards or rooms could be identified with the class of such year or with the name of one or other of our deceased or living professors, whose name could be thus honored and perpetuated.

This is the first time in the history of the school that a definite appeal has been made to its graduates and, in viewing the rally and support that has been accorded similar appeals by other medical schools, we hope that our own Alumni will show a similar interest in the future success and welfare of their Alma Mater and demonstrate this interest in a like substantial manner.

Contributions can be mailed to the treasurer of the Mercy Hospital, Sister M. Carmelita, or to the treasurer of the Alumni Association, Dr. Chas. E. Brack.

Kindly designate whether the contribution shall be used in conjunction with a class memorial.

## THE REUNION OF THE CLASS OF '96.

Much interest has been manifested by the members of the class at the prospect of a reunion. The committee feels much encouraged, owing to the warm enthusiasm with which the proposition has been received and the generous way in which this movement has been supported.

The details of the program have not been completely worked out, but the following is a general outline: The headquarters will be at the Hotel Rennert where rooms should be engaged in advance. On Monday evening, June 5, there will be an Alumni meeting. Dr. F. M. Coops will deliver the address. The meeting will be followed by a smoker at the college. For Tuesday, an automobile trip has been suggested, luncheon at a hotel or club and a visit to the new hospital. At night, the commencement will be held. On this occasion, it will be your function to don the cap and gown, once more decorate the stage and add lustre to the ceremony. The grand rally will take place at the banquet, which immediately follows the commencement exercises. The class will have a table to themselves, and the committe will see that they are bountifully provided. Dr. Brack has kindly consented to lead the salamander.

You will find elsewhere in this journal an article relating to the great

improvements to the hospital and what these improvements mean to our Alma Mater and incidentally to ourselves. It is in consequence of these significant facts that the support of the college alumni is solicited.

In view of the fact that this matter necessarily appeals to a large majority of graduates, the committee offers the following recommendation, namely, that a class fund be created, and if the proceeds are sufficient, furnish a room, preferably a recreation room or sun parlor, in the name of the class of '96 and in commemoration of one, our late professor. A contribution of this character would fulfil three definite objects, namely, perpetuate the memory of one of our worthy masters in medicine; establish a lasting record of our reunion, and assist an institution of which we should all feel justly proud.

The committee is anxious to have an expression of sentiment in this matter from those who are unable to attend the reunion.

The following members will attend:

Coggins, J.	Barnes, F. S.	Hoffman, E. A.
Wolf, Wm.	Rebuck, C. S.	Colson, J. H.
Coops, F. M.	Cook, H. F.	Jackson, W. A.
Huard, J. E.	Newth, J. A.	Harper, F. W.
McCarthy, J. J.	Lacy, J. W.	Burt, S. P.
Donohue, J. J.	Schaefer, J. E.	Knapp, H. C.
Loper, A. C.	France, H. J.	Thieme, G. C.
Fogle, F. M.	Prince, S. E.	Cotton, A.
Johnston, J. M.	Galligan, E.	Beck, H. G.
Payne, J. B.	Kisner, A. O.	Macdonald, A. W.
Arnols, J. S.	Crawford, F. H.	
Leitch, J. W.	Coby, J. C.	

## REUNION OF THE CLASS OF '91.

Dr. Wm. E. Delaney, '91, has interested himself in a reunion of his class and from present indications it seems that this meeting is an established fact. The responses have been very encouraging.

The Alumni meeting will be held at the College on Monday evening, June 5, at 8.30 p.m.

Inspection of the new hospital and the college on Tuesday, June 6, at 10 or 11 a.m.

A luncheon will be given by Dr. Percy Wade at Spring Grove, Catonsville, at 1 or 1.30 on Tuesday.

Commencement exercises Tuesday evening, June 6, at 8. p. m. Banquet on the same evening at the Rennert at 9.30 p. m.

The following names have been received:

Dr. S. E. Pennington, Dr. A. B. Straight, Dr. Bruce Clark, Dr. C. H. Saunders, Dr. S. E. Hughes, Dr. R. C. Matheson, Dr. Jas. H. Mosher, Dr. C. E. L. Keen, Dr. Geo. W. Poovey, Dr. W. E. Delaney, Dr. Jno. McReynolds, Dr. G. E. Jordan, Dr. D. C. Trach, Dr. B. E. Reeves, Dr. A. S. Todd, Dr. Aston H. Morgan, Dr. O. L. Perry, Dr. E. H. Bowling, Dr. Wm. Barron, Dr. D. W. Shirkey, Dr. C. Hampson Jones, Dr. W. A. Zellars, Dr. Percival Lantz, Dr. E. J. Spratling, Dr. G. Glass, Dr. W. B. Beaumont, Dr. Chas. B. Smith, Dr. J. Percy Wade, Dr. Everett Shipley, Dr. W. S. Gilroy. Dr. S. W. Woodyard, Dr. J. E. Glenn,

## Dbituary.

Dr. Daniel V. Moyer, '82, died at his home in Maryland Line, Md., November 9.

Dr. Frank Johnston, '83, died at his home in Trenton, N. J., September 24, from nephritis, aged 55.

Dr. John F. Michael, '85, died at his home in Morgantown, W. Va., September 26, 1910, from prostatitis, aged 70.

Dr. David M. Miller, '87, died at his home in Indian Springs, Tenn., January 8, from disease of the kidneys, aged 69.

Dr. WILLIAM BLACK ROWLAND JORDAN, '86, died at his home in Liberty Grove, Md., June 8, from ischiorectal abscess, aged 50.

Dr. Britton S. Utley, '78, a member of the Medical Society of the State of North Carolina, died at his home in Holly Springs, January 19, aged 68.

Dr. James Preston Watkins, '97, a member of the American Medical Association, and president of the council of the Chattahoochee Valley Medical and Surgical Association, died at his home in Opelika, Ala., August 18, from nephritis, aged 41.

DR. ALFRED WESLEY BEAR, for nearly forty years a practitioner of Barnard, Mo., died at his home in that place, January 21, from influenza, aged 69.

Dr. William C. Baylor, Washington University School of Medicine, Baltimore, '69, died at Willow, Cal., June 27, from cerebral hemorrhage, aged 67.

DR. JOHN BURGESS GAITHER, '69, a member of the Medical Society of the State of North Carolina, died at his home in China Grove, December 17, aged 63.

DR. JOHN HENRY FINCH, '86, a member of the Medical Association of the State of Alabama, died at his home in Birmingham, January 11, from paresis, aged 52.

Dr. C. H. O. Young, '75, a member of the Kentucky State Medical Association; a practitioner of Flippin, Ky., for forty years, died at that place, April 22, aged 64.

DR. JOHN J. SWEENEY, '10, of Govanstown, Baltimore, died in Mercy Hospital, February 18, from the effects of bichloride of mercury, self-administered in mistake for candy, aged 25.

Dr. Monmonier Rowe, '81, major of the First Battalion of the Fourth Infantry, Maryland National Guard, died suddenly at his home in Baltimore, December 31, from nephritis, aged 51.

Dr. Joseph Lacy Brayshaw, '88, of Friendship, Md., a member of the Medical and Chirurgical Faculty of Maryland, died in Sibley Hospital, Washington, D. C., October 30, aged 55.

Dr. George P. Yost, Washington University School of Medicine, Baltimore, '71, of Glen Rock, Pa., died at the home of his son-in-law in Baltimore, June 12, from heart disease, aged 62.

Dr. William E. Brown, '84, a member of the South Carolina Medical Association, for several terms intendant of the town of Manning, died at his home, December 5, from nephritis, aged 54.

DR. HENRY LEVI BEVANS, Washington University, Baltimore, '69, a member of Garrett County Medical Society, died at his home in Grantsville, Md., September 27, from paralysis, aged 66.

Dr. Joel Hill, '80, a member of the Medical Society of the State of North Carolina, and Association of Surgeons of the Southern Railway, died at his home in Lexington, November 22, aged 55. Dr. John M. B. Rogers, '77, of Ellicott City, a member of the Medical and Chirurgical Faculty of Maryland, died at the home of his sister in Govans, Md., October 31, from typhoid fever, aged 62.

Dr. Andrew Strang, '80, formerly of Wilkes-Barre and Scranton, Pa., died in Largs, Scotland, September 10, from epithelioma of the tongue for which operation had been performed a year before, aged 64.

Dr. Robert Gildea O'Hara, '85, formerly an officer in the English service; a member of the Medical Society of Virginia; physician for the Elks' National Home, and chairman of the Board of Health of Bedford City, died in St. Andrew's Hospital, Lynchburg, November 13, from heart disease, aged 54.

Dr. Robert Hunter Duncan, '85, for several years surgeon for the Pacific Mail Steamship Company; a specialist on diseases of the eye and ear, of Brooklyn; a member of the staff of the Manhattan Eye and Ear Hospital, New York City; the Eye and Ear Infirmary of Long Island College Hospital, and Williamsburg Hospital, died in the Jamaica Hospital, October 31, aged 48.

Dr. William Franklin Hines, '87, formerly of Chestertown; a member of the Medical and Chirurgical Faculty of Maryland, and chief of the Bureau of Vital Statistics of the State Department of Health; for four years a member of the State Board of Medical Examiners; for ten years health officer of Kent County, and for two years superintendent of the State Bureau of Immigration, died at his home in Baltimore, October 17, from cirrhosis of the liver, aged 54.

## Personal Motes.

Dr. C. W. Spangler, '83, has removed from Jared to Thorpe, West Virginia.

Dr. John J. Burne, '10, has located at Newark, New Jersey, where he has an office at 558 Central Ave.

Dr. D. C. Patterson, '06, Bridgeport, Connecticut, has been appointed lecturer on hygiene at the Young Women's Christian Association.

Dr. Samuel J. Fort has removed his private home for nervous and mental diseases from Ellicott City, Maryland, to Gelston Heights, Baltimore City.

Dr. Charles Walter Maxson was married to Miss Addie M. Weston at Baltimore, April 12, 1911. They will make their home in New Cumberland, West Virginia.

Dr. Earl Cross was married to Miss Florence Stultz, Thursday, August 25, 1910. They will make their home at Curtisville, Pennsylvania, where Dr. Cross is located.

Dr. Spencer M. Free, Dubois, Pennsylvania, has been elected president of the Railway Surgeons' Association, which consists of the surgeons of the Pennsylvania lines east of Pittsburg.

DR. AUGUST FERDINAND RIES was married to Miss Fannie Morris Gardner, daughter of Mr. and Mrs. M. Morris Gardner, of New Rochelle, New York. The marriage took place February 16, 1911. Dr. and Mrs. Ries are now at home at 24 South Broadway, Baltimore, Maryland.

DR. LOUIS E. BROWN, '03, who practiced for five years at Fort Wayne, Indiana, has been located for the past year in Frederick, Md., where he is devoting his attention chiefly to diseases of children. Dr. Brown took a special course for five months in 1909 at St. Christopher's Hospital for Children in Philadelphia.

Dr. Benjamin Spotswood Preston was married to Miss Dannie Kate Rogers, daughter of Dr. and Mrs. E. S. Rogers, of Knoxville, Tennessee. The wedding ceremony was held at the Centenary Church, Wednesday evening, January 25, 1911. Dr. and Mrs. Preston will make their home in Charleston, West Virginia.

Dr. George O'Hanlon has been appointed by the trustees of Bellevue and Allied Hospitals medical superintendent of Bellevue Hospital to succeed Dr. W. H. Smith, who goes to the Johns Hopkins in Baltimore. Dr. O'Hanlon is a graduate of the College of Physicians and Surgeons of Baltimore, and has been for the past year first assistant superintendent of Bellevue.

DR. W. J. WALKER, Mabscott, West Virginia, has in company with Mr. G. C. Hedrick, purchased all the property of the Beaver Coal Company lying between Mabscott, Raleigh and Beckley, with the exception of a few small tracts. In all the territory amounts to about 150 acres, the value of which is in the neighborhood of \$50,000. This will be used for sites for factories and other purposes, and will give quite an impetus to the neighboring towns.

Dr. Samuel Darling, pathologist to the Medical Commission of the Panama Canal Zone, is located at the Ancon Hospital and has been elected a corresponding member of the Société Pathologie Exotique of Paris. This is a recognition of Dr. Darling's excellent original work, which comprises studies in malaria and in numerous other diseases found in the tropics.

Dr. J. EVERETT PICKERING is taking a special course in surgery at Harvard.

The American Mutual Liability Insurance Co. recently appointed Dr. Pickering surgeon to the Norway Worsted Co., Francis Willey Co., Barre Wool Combing Co. and White Bros.' mills.

In addition to these, Dr. Pickering is medical inspector in the public schools of Oakham, is agent of the Oakham board of health, surgeon for the Italian society of South Barre, medical examiner for the Mutual Life of Worcester, Phenix Life of Hartford and Travelers Accident.

## Correspondence.

## CLASS OF '92 PLEASE NOTE.

CENTRAL FALLS, R. I., December 13, 1910.

Dear Doctor.—Enclosed find check in payment for my subscription to the Journal. I think if the class of '92 would hold a reunion in 1912 I would endeavor by all means to attend. Probably if you mention it in the Journal some of the boys of '92 would get up a reunion. Hoping that such a reunion might take place. I remain,

Yours truly,

Dr. Geo. J. Howe.

Webster Springs, W. Va., December 14, 1910.

Dr. Chas. E. Brack, Baltimore, Md.

Dear Doctor.—Enclosed find check of two dollars for my subscription to the JOURNAL. I enjoy reading the articles from the pen of my teachers and schoolmates. Please change my address from Birch River, W. Va., to Webster Springs, W. Va., and oblige.

Yours truly,
J. B. Dodrill, '09.

FINDLAY, OHIO, October 7, 1910.

CHAS. E. BRACK, M. D.

Dear Doctor.—I enclose, with much pleasure, \$1.00 as subscription fee for the Journal.

I wish you would try to get up a little interest among the boys of the class of '93—which was a "dandy" in more ways than one—so we can have a little gathering of our own next Alumni meeting. Am just leaving for the meeting of the N. W. Ohio annual session, of which society, I am vice-president. With kindest regards,

Fraternally yours,

DON C. HUGHES.

MONETT, MISSOURI, November 29, 1910.

DR. CHAS. E. BRACK, Treas., Baltimore, Md.

Dear Doctor.—Enclosed please find draft for \$2.00 in payment of my subscription to the Association Journal for 1909 and 1910.

I always enjoy reading the JOURNAL, and appreciate every line it contains; would be glad to have a number each month.

With best wishes for its continued success, I am,

Yours truly,

A. S. HAWKINS, '79.

MABSCOTT, W. VA., November 27, 1910.

DR. CHARLES E. BRACK.

Dear Doctor Brack.—Since graduating at P. & S. in 1908, have been located at Mabscott, West Virginia, where I have the contract work for two of the largest coal mines in this section, I am also surgeon to two railways, C. & O. and the P. R. & P. C. I am not setting the world on fire by any means, but have been fairly successful, both financially and professionally, in so far as it lies within the power of the proverbial country doctor.

I am appending clipping from local paper of recent issue, thinking that it might be of some interest to you.

When you feel "The Call of The Wild" and desire to spend a few weeks hunting and fishing, why just come down and I will arrange the rest.

Yours fraternally,

WILLIAM J. WALKER,

PERTH AMBOY, N. J., October 11, 1910.

DR. CHAS. E. BRACK.

My dear Doctor.—Opened your letter last night. Am enclosing check. Was away or I would have sent check earlier.

You probably know of the recent trip of Mrs. Tyrrell and myself "Around the World." Sorry you were not along. Had a big time. With best wishes.

Yours verily,

G. W. Tyrrell, Class '93.

MORGANTOWN, W. VA., October 12, 1910.

CHARLES EMIL BRACK, M. D., Baltimore, Md.

Dear Doctor Brack.—Enclosed find check for one dollar as per statement enclosed.

I certainly enjoy the JOURNAL very much as it is one of the few means I have of keeping in touch with the "Old School" and the "boys" whom I knew there.

With kindest regards to yourself, other members of the faculty and any of my old class mates who may be in Baltimore. I am,

Fraternally yours,

EVERETT R. TAYLOR, '07.

McKeesport, Pa., November 23, 1910.

Dr. CHARLES EMIL BRACK.

My dear Doctor.—Enclosed find check for two dollars, my subscription to the Journal for 1909 and 1910. The Journal came to-day and I enjoyed it very much.

Respectfully,

H. S. NEWLIN, '83.

POCOMOKE CITY, MD., January 7, 1911.

DR. C. E. BRACK.

Dear Doctor.—Enclosed find check for subscription to the JOURNAL. It was with regret that I read of Tarter and Prezioza's death. I had not heard of eithers demise until I received the JOURNAL.

Wishing you the compliments of the season.

Yours very truly,

A. A. PARKER.

## DR. STULTZ STARTS A SANATORIUM.

SUPPLY OKLAHOMA, Feb. 14, 1911.

Dr. Chas. E. Brack, 500 E. Twentieth St., Baltimore, Md.

Dear Doctor.—Have received copies of Journal of Alumni Association and am sending you check for one years' subscription, beginning with the January issue.

I am contemplating turning an old Virginia country home into a home for the care of a limited number of mentally defective or chronically insane, and would like to get into communication with those who have relatives or a member of the family who need such care.

I have had 12 years in active general practice and this is my third year in hospital work in the Oklahoma State Hospital for Insane. I have had considerable experience in the care of incurables and see the necessity of a retreat for these unfortunates whose relatives are able and willing to pay for their care. Any assistance or suggestions you may give me along this line will be very highly appreciated.

Yours fraternally,

P. H. STULTZ.

See advertisement on last page.

JACKSONVILLE, FLA., February 10, 1911.

Dear Dr. Brack.—While in Baltimore last fall I did not get a chance to see you again to pay you for the Journal, so I am inclosing my check for \$2.00. You can change the address of my Journal to Jacksonville, as you can see from the above that I have changed my location from Madison, Fla., to Jacksonville. I have been here about two weeks and, of course, business is slow.

If you ever come to Florida be sure to look me up.

Sincerely yours,

GEO. O. DAVIS.

Dear Doctor Brack.—Enclosed you will find \$2.00 in payment for our Journal. Happened to be in Baltimore for a few days and naturally looked in to see our Mr. Annan. I am in Boston for the last 5 years and doing well.

My address is 113 Chambers St.

Sincerely,

M. SALTZ.

STANDARD, W. VA., October 25, 1910.

Dr. C. E. Brack, Baltimore, Md.

Dear Doctor.—Please find enclosed one dollar for subscription to the Journal. Please accept thanks for your kindness in the spring, in securing a substitute. Dr. Juslius Royal-Fisher proved to be a very competent man. He passed West Virginia State Board. He is now in Akron, Ohio. With kindest regards for past favors, I remain,

Fraternally

D. E. MUSGRAVE.

GILBOA, N. Y., December 22, 1910.

CHAS. EMIL BRACK, M. D., 500 East 20th St., Baltimore, Md.

Dear Doctor.—Find enclosed check for two dollars, my dues for 1910 and 1911. Am always pleased to get the JOURNAL, and usually read it all if I am not too busy.

Wishing yourself and all members of the Alumni a merry Christmas,
I am, very truly yours,

E. S. Persons.

THORPE, W. VA., October 18, 1910.

Dear Doctor Brack.—Enclosed find check for \$1.00 amount for subscription to Alumni Journal for 1910. Place same to my credit. Wishing you and all the Alumni success, I am,

Fraternally yours,

C. W. Spangler, '83.

THE AMERICAN PROCTOLOGIC SOCIETY'S PRIZE FOR THE BEST ORIGINAL ESSAY ON ANY DISEASE OF THE COLON BY A GRADUATE OF (NOT A FELLOW OF THE SOCIETY) OR A SENIOR STUDENT IN ANY MEDICAL COLLEGE OF THE UNITED STATES OR CANADA.

The American Proctologic Society announces, through its committee, that the cash sum of \$100 will be awarded, as soon of possible in 1911, to the author of the best original essay on any disease of the colon in competition for the above prize.

Essays must be submitted, to the secretary of the committee, on or before May 10, 1911. The address of the secretary is given below, to whom all communications should be addressed.

Each essay must be typewritten, designated by a motto or device, and without signature or any other indication of its authorship, and be accompanied by a separate sealed envelope, having on its outside only the motto or device contained on the essay, and within the name, the motto or device on the

essay, and the address of the author. No envelope will be opened except that which accompanies the successful essay.

The committee will return the unsuccessful essays, if reclaimed by their writers within six months, provided return postage accompanies the application.

The committee reserves the right not to make an award if no essay submitted is considered worthy of the prize.

The competition is open to graduates of medicine (not fellows of the Society), and to members of the senior classes of all colleges in the United States or Canada.

The object of the prize and competition is to stimulate an increased interest in, and knowledge of proctology.

The committee shall have full control of awarding the prize and the publication of the prize essay, and it shall be the property of the American Proctologic Society. It may be published in the Transactions of the Society and also as a separate issue if deemed expedient. The committee may increase its membership if deemed advisable.

DR. DWIGHT H. MURRAY, Chairman,

DR. SAMUEL T. EARLE,

DR. JEROME M. LYNCH,

DR. ALOIS B. GRAHAM,

Dr. Lewis H. Adler, Jr., Secretary, 1610 Arch St., Philadelphia, Pa.

## A NEW LINE OF PARKE, DAVIS & CO.

"Everything under the sun for physicians" might be suggested as a motto not inappropriate for Parke, Davis & Co. The thought is prompted by the recent incursion of the company into the field of surgical dressings. It was something like a year ago, if we mistake not, that Chloretone Gauze and Formidine Gauze were launched in modest fashion, the purpose evidently being to let them find their way into the medical armamentarium in the natural order of events rather than by artificial fostering. Their reception by the profession must have been gratifying, for the line soon began to expand. Now it numbers six gauzes and tapes, and we note a disposition on the part of the company to bring them more prominently to the attention of physicians. For this reason a word or two in explanation of them may not be out of place.

The line includes Chloretone Gauze, Formidine Gauze, Formidine Tape, Adrenalin Tape, Plain Tape and Anesthone Tape. What has been said of the therapeutic properties of Chloretone, Formidine, Adrenalin and Anesthone (and most physicians are well acquainted with these products) is applicable to the surgical dressings. Chloretone Gauze, applied to raw surfaces, exerts an anesthetic and antiseptic action, promoting the comfort of the patient. It is markedly useful in extensive burns. Formidine Gauze takes the place of iodoform gauze. It is more actively antiseptic, does not stain the clothing, is non-toxic, and is practically odorless. Formidine Tape, which comes in two widths (½ inch and 1½ inches), is used for packing cavities antiseptically. Adrenalin Tape, supplied in ½ and 1½-inch widths, is serviceable in tamponing cavities to check hemorrhage. Plain Tape, which also comes in the two widths above mentioned, is used for packing and draining small

wounds and cavities. Anesthone Tape is serviceable in the various forms of nasal hyperesthesia. All of the tapes are double-selvaged and when removed from wounds do not leave short threads to cause irritation.

Parke, Davis & Co. issue a small pamphlet descriptive of their medicated gauzes and tapes. Physicians who have not received a copy are advised to write for one. The dressings are pretty generally carried in well-stocked pharmacies.

#### A VALUABLE LOCAL ANESTHETIC IN ANO-RECTAL SURGERY.

In view of current interest in Quinine and Urea Hydrochloride as a local anesthetic, a report of Dr. Louis J. Hirschman, of Detroit, which appeared in a recent number of the Cincinnati Lancet-Clinic, has peculiar pertinency. Dr. Hirschman reports a total of 102 operations, comprising acute thrombotic hemorrhoids, internal hemorrhoids, internal hemorrhoids, fistula in ano, perineal abscess, fissure in ano, excision of scar tissue, Ball's operation (pruritus ani), hypertrophied papillæ, and inflamed Morgagnian crypts. Perfect results were obtained in every case so far as operative anesthesia was concerned, and in but seven cases was there any post-operative pain. The doctor uses the one-per-cent solution in all of his cases of ano-rectal surgery when suturing of the skin is required. The technique of administration is the same as that with weak solutions of cocaine and eucaine.

Dr. Hirschman believes that the substitution of Quinine and Urea Hydrochloride for any of the other anesthetic salts hitherto employed will prove eminently satisfactory in all cases of ano-rectal surgery in which suturing of the integument is not required. He sums up its advantages as follows: it is soluble in water; it can be sterilized; it is equal to cocaine in anesthetic power; it is absolutely non-toxic; it has a pronounced hemostatic action; it produces persistent anesthesia; it is inexpensive.

Quinine and Urea Hydrochloride, in one-per-cent sterilized solution, is supplied by Parke, Davis & Co. in sealed glass ampoules of five cubic centimeters capacity. An ampoule is opened by breaking off the tip, when the hypodermic needle can be inserted in the neck of the ampoule and the solution drawn into the syringe. Parke, Davis & Co., by the way, issue a sixteen-page brochure on "Local Anesthesia with Quinine and Urea Hydrochloride," which should be in the hands of every physician and surgeon. The pamphlet details fully the uses of the new anesthetic, explains the technique of administration, and contains some valuable case reports. A copy may be obtained by writing the company at its home offices in Detroit.

Hypodermic tablets that are not freely and completely soluble in the barrel of your syringe are not only unsatisfactory, but may cause trouble. Not only is the dose thereby made insufficient—for when you want to give a quarter grain, a fifth or a sixth of a grain will not produce the desired result—but small undissolved fragments that can pass through the needle into the tissues often establish inflammatory foci that develop into abscesses.

These remarks suggested themselves when we read the new announcement of "the hypodermic tablet people" that appears elsewhere in this month's JOURNAL. Sharp & Dohme are to be congratulated upon their consummate skill in making really soluble hypodermic tablets.



Cacodylate of Sodium, an organic arsenical product, is offered as a superior substitute for the ordinary inorganic arsenical preparations. It has been administered with striking success in the treatment of

# Syphilis,

the best results following the use of comparatively large doses—2 to 4 grains—smaller doses, while serviceable in other diseases amenable to arsenic, being of little avail in syphilis.

The malarial cachexia, neurasthenia, certain diseases of the skin (as psoriasis), leukemia and Hodgkin's disease are also within the province of sodium cacodylate medication.

#### Cacodylate of Sodium.

1 Cc. sealed glass ampoules, each containing 3/4 grain of the salt, and 1 Cc. ampoules of 3 grains each, boxes of 12.

Quinine and Urea Hydrochloride, within a comparatively recent period, has come into extensive use as a

## Local Anesthetic,

taking the place, to a considerable extent, of cocaine, to which, being nontoxic even in large doses, it is preferable, especially for purposes of injection. Another advantage is its tendency to restrain or prevent hemorrhage. It produces anesthesia that persists sometimes for hours—occasionally for days—a valuable feature in connection with rectal and other operations that may be classed as painful. Minor surgery offers a wide field for this preparation.

### Quinine and Urea Hydrochloride.

5 Cc. sealed glass ampoules, each containing 80 minims of a 1-per-cent. solution, boxes of 12.

THE SPECIFICATION "P. D. & CO." WILL INSURE ABSOLUTELY STERILE SOLUTIONS.

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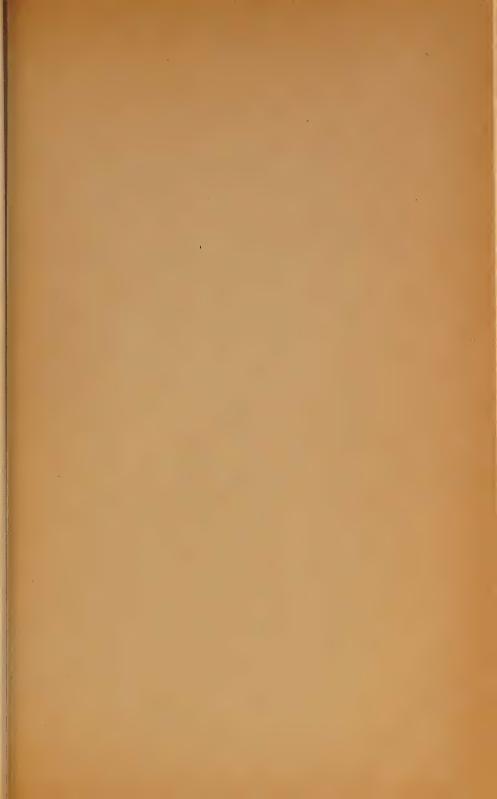


## A QUIET, SECLUDED COUNTRY HOME FOR THE CHRONIC INSANE AND MENTALLY DEFICIENT

Dr. P. H. Stultz ('95) offers unusual facilities in supplying a real home for a limited number of chronic insane or mentally deficient patients.

Dr. Stultz has had considerable experience in institution work and appreciates the advantages of an asylum and home rather than a hospital for a certain class of these unfortunates.

For special information address, Dr. P. H. STULTZ, Supply, Okla.



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Professor of Chemistry.
JOHN W. CHAMBERS, M. D., Sc. D.,
Professor of Principles and Practice of Surgery and Clinical Surgery.
NATHANIEL G. KEIRLE, A. M., M. D., Sc. D.,

and Clinical Surgery.

NATHANIEL G. KEIRLE, A. M., M. D., Sc. D.,
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Director of Pasteur Institute.
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WILLIAM ROYAL STOKES, M. D., Sc. D.,
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HARRY FRIEDENWALD, A. B., M. D.,
Professor of Ophthalmology and Otology.
ARCHIBALD C. HARRISON, M. D.,
Professor of Anatomy and Clinical Surgery.
WILLIAM P. SPRATLING, M. D.,
Professor of Physiology and Diseases of the
Nervous System.
WILLIAM S. GARDNER, M. D.,

Nervous System.

WILLIAM S. GARDNER, M. D.,
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Professor of Hygiene and Public Health.
JULIUS FRIEDENWALD, A. M., M. D.,
Professor of Gastro-Enterology.

JULIUS FRIEDENWALD, A. M., M. D.,
Professor of Gustro-Enterology.

JOHN RUHRÄH, M. D.,
Professor of Diseases of Children, Therapeutics and Clinical Medicine.
CARY B. GAMBLE, JB., A. M., M. D.,
Professor of Clinical Medicine.
STANDISH McCLEARY, M. D.,
Professor of Olinical Medicine.
CHARLES E. BLAKE, Ph. B., M. D.,
Professor of Operative Surgery and Clinical Professor of Diseases of the Rectum.
CHARLES E. SIMON, M. D.,
Professor of Olinical Pathology and Expertmental Medicine.
FRANK DYER SANGER, M. D.,
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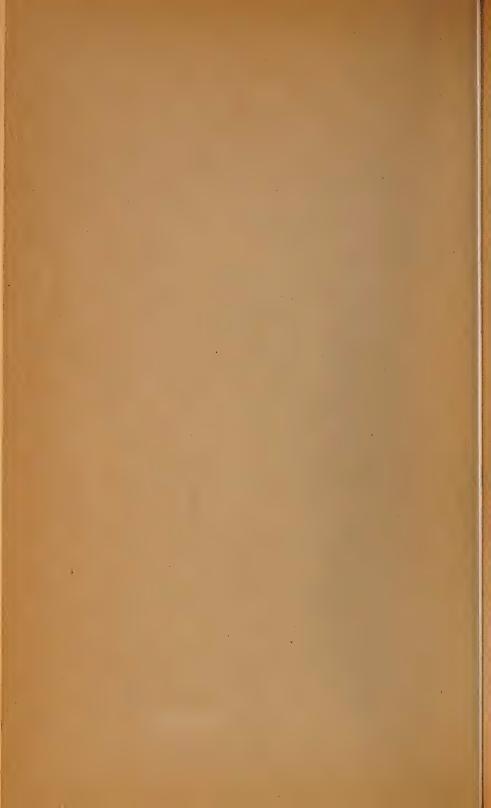
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## THE JOURNAL

### OF THE ALUMNI ASSOCIATION

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### COLLEGE OF PHYSICIANS AND SURGEONS,

#### BALTIMORE.

### REPORT ON THE TREATMENT OF SYPHILIS BY INTRA-VENOUS INJECTIONS OF SALVARSAN.\*

(From the Departments of Genitourinary Surgery, Dr. Charles F. Bevan, Chief, and Experimental Medicine of the College of Physicians and Surgeons, Dr. C. E. Simon, Chief.)

BY A. G. RYTINA, M. D., BALTIMORE.

Some recent reports appearing in the American literature regarding the therapeutic value of salvarsan lead one to the belief that it possesses only a doubtful value in the successful combating of syphilis, and at most, should be regarded only as an adjunct to the usual routine treatment of this affection.

If one analyzes these reports carefully, he will learn that the authors have had either very little or no personal experience with the drug, or that they are still desisting from the employment of the intravenous mode of application which Ehrlich for some time has been recommending as the proper way of administering the compound.

In our early experiences with salvarsan, we tried both the subcutaneous and intramuscular injections, and our results corresponded with the adverse reports alluded to in the literature. Since using the intravenous injections, however, our results have been so different, and in most instances so brilliant, that we consider this the only method of applying the drug, and that poor results based on any but this method should be totally disregarded. Up to the present time we have treated, by the intravenous method, about sixty cases, and while sufficient time has not elapsed to speak of the final outcome to be obtained in this series, it might be of interest to show the wonderful symptomatic efficiency of this drug by the intravenous method of application.

<sup>\*</sup> Reprinted from the New York Medical Journal for March 4, 1911.

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We are still carefully observing all our cases where possible, and in due time will report on results concerning recurrences, failures, complications, etc. Up to the present time we have not had any recurrence, and in not a few of our cases good results have been obtained where the usual mercury and iodide cure had entirely failed. In only one patient did the injection fail to produce marked improvement within one week, on which account he was reinjected. Following the second injection the patient immediately began to improve and at the present writing is very much better.

In our present report we propose to detail only the history of the patients who had active lesions, who have been observed for at least thirty days, and who have been under Wassermann test control. The following is the routine we follow: Heart, lungs, nervous system, and urine are carefully examined; eye examinations in suspicious cases; Wassermann reactions made just before and at varying intervals after the injection. If the reaction is present after the expiration of forty days, or becomes positive after a negative phase, we give another intravenous injection. In the open lesions, spirochætæ examinations are made daily before and after the injection until their disappearance (usually in from twenty-four to forty-eight hours). If they show motility after seventytwo hours, we advise reinjection notwithstanding marked improvement of the lesions, for, according to Ehrlich, salvarsan is specific, and if the spirochætæ do not disappear within from twenty-four to forty-eight hours, one of three conditions obtain: Either the dose has been too small, or there has been defective absorption, or we are dealing with a strain of spirochætæ which are arsenic fast. Before giving the second injection we wait at least one week. This has been found necessary in only two of our cases. Both of these patients had numerous anal condylomata and severe mouth lesions. Four days later after the injection the mouth lesions healed, the condylomata became more flat and very dry, but active spirochætæ were still demonstrable, on which account the patients received, three days later, another intravenous injection (0.6 gramme). As is usual, the reaction following the second injection was less intensive than the first. At the present writing (thirteen days after injection), all of the condylomata have practically disappeared in the first case. This patient's lesions resisted the most active mercurial treatment in the last two months. The other patient is progressing finely, the condylomata are very dry and flat, and examination for spirochætæ was negative, although the lesions are still quite visible.

In most of our early cases, the intravenous injections were given by the canula method, which is exactly similar to the operation done for venous transfusion of normal salt solution. Recently we have been employing the original Schreiber method, reserving the canula method for those rare cases where the Schreiber method is impracticable. The operation is absolutely painless and free from local reactive phenomena or complications, unless leakage in the cellular tissues occur. This occurred only in one of our early cases.

The reaction phenomena following the intravenous injection are more prompt and more intensive than in the other two methods. They consist of chills, fever (never over 102.5° F.), sweats, nausea, vomiting, diarrhea, dryness of the throat, thirst, leucocytosis, rapid pulse, etc. We have not observed Herxheimer's reaction in any of our cases, but in several instances have noted eruptive phenomena following shortly after the injection, which promptly disappeared. In only one of our cases did disturbing symptoms develop. This was in a patient in whom severe shock developed, following rapid injection, and retention of urine lasting forty-eight hours. In patient No. 2 we got leakage, which causes much pain and similar local phenomena as follow the intramuscular injection of the alkaline solution. We have noticed that in active cases more marked reactions develop than in the latent types of the disease, owing, no doubt, to the large spirochætæ destruction with consequent liberation of large amounts of endotoxines. Those patients in whom severe reactions develop do better, as a rule, than those whose reactive phenomena are slight. We have not noted any supersensitiveness develop following the second injection; on the contrary, it is less intensive. On this account, if the patient's reaction was not very severe after the first injection, at the time of the second injection he was given as large or a larger dose, often with gratifying results. In one sickly looking patient (weight 110 pounds), with gummata of the testicles and severe headaches, 0.4 gramme caused very little reaction and failed to improve his condition. Reinjection (0.6 gramme) caused very prompt improvement.

#### WASSERMANN TEST RESULTS.

The Wassermann reaction was investigated before treatment in thirty of the cases. The results are seen in the first column of the accompanying table:

	I.				
	Number of cases.				
	30	土	+	++	+++
Primary	0				
Primary and secondary	3			• •	3
Secondary	8			. 3	5
Tertiary	11	1		• •	10
Latent	4		2	1	1
Parasyphilis	3	1			2
Congenital	1	• •	• •		1
	TT				

11.												
Number of cases.		n. <del></del>	Neg-									
7	± '	+	++	+++	ative.							
Primary 1	1											
Primary and secondary 2					2							
Secondary 1					1							
Tertiary 3				1	2							
Latent 0	• •											
Parasyphilis 0												
Congenital 0	• •											

Following the treatment we now have the Wassermann reaction results in seven cases of the series in which a time limit of forty days has been reached or exceeded. The results will be seen in the second column of the accompanying table. From this it is apparent that the reaction has disappeared in 71.5 per cent of the cases falling under this heading, while in 28.5 per cent it still persists, or has become positive.

In a disease so protean as syphilis, it would be folly to attempt to predict the ultimate results to be attained by this new drug. It seems certain that Ehrlich's ambition of magna therapia sterilisans has not been realized. It is noteworthy, however, that practically all of the poor results reported have been by the subcutaneous or intramuscular method, and that Schreiber has reported over 800 cases by the intravenous method with only four recurrences and no deaths, complications, etc. In our own series we have not as yet had any recurrences and only one patient had to be reinjected on account of failure of the first injection to pro-

duce the desired result. In another patient (No. 4), after marked improvement, the disease became stationary, and he has been advised to have a reinjection. Two patients, as already noted, received a second injection because spirochætæ pallidæ were present after four days, and one received the second injection because after forty days he had a slightly positive Wassermann reaction.

#### CONCLUSIONS.

From our studies and experience, we feel justified in drawing the following conclusions: 1. Salvarsan possesses wonderful symptomatic efficiency. 2. Intravenous injection is practically harmless, gives rise to neither pain nor complications, and is productive of better results than are obtained by either the subcutaneous or intramuscular methods; furthermore, it produces results more quickly than can be attained by either mercury or potassium iodide, and very often cures lesions where heroic doses of mercury and potassium iodide have failed. 3. On account of its wonderful spirillocidæ action syphilis will be less prevalent and there will be less liability to tertiary manifestations and the development of parasyphilis, after the proper method of treatment has been fully ascertained. Whether this be the "chronic" injection treatment of Kromayer, the combination method of Iversen, injections every forty days as long as the Wassermann reaction persists, or the reinforcement of injections by courses of mercury and potassium iodide, for from six months to two years, only the future can tell.

Case I.—Age, eighteen; single. Initial lesion, August 17, 1910. Indurated chancre surrounding meatus and extending into urethra. Papular syphilide all over body. Phimosis owing to balanoposthitis. General glandular enlargement. Spirochætæ pallidæ in large numbers. Wassermann reaction +++.

November 21, 1910. 0.5 gramme salvarsan injected intravenously.

November 22. Examination for Spirochæta pallida negative. Little reaction. Temperature, 101.2° F. Eruption same.

November 24. Eruption on arms had almost entirely disappeared and eruption over body disappearing. Inguinal enlargement same.

November 26. Eruption on arms disappearing. Over body only pigmentation at site of former eruptions seen. Patient could retract foreskin and only scar seen at site of former chancre.

November 28. Patient felt fine. No recurrence. Wassermann reaction  $+ + + + \cdot$ 

January 21, 1911. Patient felt fine. No recurrence. Wassermann reaction 0.

CASE II.—Age, twenty-one; single.

Initial lesion and secondaries, four years ago. Treatment irregular.

January, 1910. Ozæna, necrosis nasal side of the superior maxilla, progressive ulceration of the inner surface extending to the right margin of the ala exteriorly. Large serpiginous ulcer on right chest. Notwithstanding heroic doses of mercury internally and intramuscularly, and potassium iodide, etc., and local treatment to nose, lesions kept on progressing.

Wassermann reaction +++.

November 21, 1910. 0.45 gramme of salvarsan intravenously.

November 22. Owing to leakage, for six hours patient had much pain and severe local symptoms. No more pain in nose.

November 26. Nose and chest lesions showed decided improvement. Scab on chest had fallen off entirely.

November 28. Lesions in exterior part of nose were dry and clean, about one-fourth former size, and covered by a healthy scab.

December 2. Report by Dr. Cohen: "The entire ulceration on inside of ala has healed, that on the outside almost healed, being still covered by a small crust which dropped off about December 6, leaving only a small scar. The interior of nose is now entirely clean, there being no signs of ulceration or crusts at this time. Although nose is not douched regularly, it is perfectly clean and free from odor."

Remarks.-Dr. Cohen informs me lesions followed operations on nose, patient at time of operation did not give luetic history.

Case III .-- Age, twenty-two; single.

Infection September 25, 1910. Indurated sore at meatus, extending into urethra one-half inch. Slight edema of prepuce. General glandular enlargement. Macular eruption on chest, front and back. Examination for Spirochæta pallida positive. Wassermann reaction +++.

On November 25, 1910. 0.45 gramme salversan injected intravenously.

November 26. Severe reaction. Temperature, 101.3° F., followed two hours after injection. Chancre smaller, softer and cleaner. No change in glands. Eruption over body already showed a tendency toward recession.

November 28. Chancre still improving, about one-fourth former size, eruption disappeared, showing now only pigmentation at site of former eruptions. Glands smaller.

December 4. No signs of any eruption. Chancre entirely healed.

December 24. No signs of recurrence. Wassermann reaction +++. January 21, 1911. No signs of recurrence. Wassermann reaction 0.

Case IV .-- Age, twenty-four; married.

Initial lesion one and a half years ago. Previous treatment had been indefinite. Syphilitic gumma of right and left testicle; right, size of pear, associated with hydrocele of cord; left a little larger than normal; both felt very hard. Wassermann reaction +++.

December 5, 1910. 0.5 gramme of salvarsan injected intravenously.

December 6. Rather severe reaction followed injection. No change in testicles noted.

December 7. Right testicle seemed smaller. No change in consistency. Left same.

December 10. Very marked improvement in both testicles, being decidedly

softer and smaller. Improvement on left side was so marked that it felt normal in size and consistency.

December 17. The right testicle was just a trifle larger than normal, but consistency very firm. Left normal.

January 11, 1911. Right testicle had remained stationary since last examination, testicles being about the same size and consistency. Wassermann reaction +++.

Patient felt fine and considered himself well, on which account he refused reinjection.

CASE V.—Age, twenty-four; married; female.

Patient denied any knowledge of infection. Had at present syphilitic ulcer on left thigh about three inches in diameter by one and a half inches in depth, of eight months standing. Had been taking mercury and potassium iodide all this time. Wassermann reaction +++.

November 13, 1910. 0.7 gramme salversan injected intravenously. (Dr. White.)

November 14. Marked prostration, vomiting, and urticarial eruption over face and neck followed injection. Temperature, 102.4° F. Blood pressure after injection 95. Leucocyte count 22,000.

November 24. Ulcer healing rapidly.

December 5. Ulcer completely healed.

December 10. Wassermann reaction 0.

CASE VI.-Age, twenty-two; single.

Initial lesion of three weeks' duration consisting of two typical indurated sores at under surface of prepuce. General glandular enlargement. Examination for *Spirochæta pallida* positive.

December 5, 1910. 0.5 gramme salvarsan injected intravenously.

December 6. Chancres showed marked improvement, being smaller, cleaner, dryer, and less indurated. Examination for *Spirochata pallida* negative.

December 10. Smaller chancre healed; larger, about one-third former size. Glands in inguinal region smaller. Examination for Spirocheta pallida negative.

December 15. Chancre had entirely healed. Glands in groin still a little enlarged.

January 16, 1911. Patient felt fine. Had few herpetic eruptions behind corona. Had had herpes before chancre appeared.

January 21. Wassermann reaction +.

January 26. Intravenous injection, 0.6 gramme salvarsan.

Remarks.—While patient felt fine, had gained in weight, and no secondaries had developed, he was given second injection because after forty days there was still a slight Wassermann reaction.

CASE VII.—Age, thirty-one; married.

Initial lesion, July, 1910, followed by secondaries. Following treatment eruptions over body disappeared, but lesions in mouth persisted consisting of mucous patches over the tongue and inner lip. Both tonsils and posterior pharyngeal walls showed one mass of ulceration, covered by a thick, whitish, exudation. Deglutition very painful. For the last four weeks large doses of protiodide hypodermic injections of salicylate, and potassium iodide. Lesions progressing. Examination for Spirocheta pallida positive on numerous examinations. Wassermann reaction +++.

December 8, 1910. 0.5 gramme of salvarsan injected intravenously.

December 10. Lesions in throat not improved. Numerous patches on tongue and inner lip improved. Deglutition painless.

December 11. On right side lesion about half healed. Left side showed decided improvement, but not so marked as on right side. Numerous patches on tongue and inner side of lip entirely healed. Examination for *Spirochæta pallida* negative.

December 12. Right side practically healed and left side granulating nicely. December 16. Throat entirely healed.

December 24. No recurrence. Wassermann reaction +++. January 21, 1911. No recurrence. Wassermann reaction 0.

As can be seen at a glance, improvement was marked and prompt in every case. The Wassermann reaction became negative in Cases I, II, III, V and VII. In Case IV it had persisted. This patient's gumma at the beginning showed decided and progressive improvement, but in the last two or three weeks it remained stationary. He refused reinjection.

Patient No. 6 had two chancres, which promptly healed following the injection, and while secondaries did not develop, a beginning positive Wassermann reaction caused us to advise reinjection, which he received on January 26, 1911 (0.6 gramme of salvarsan intravenously).

#### THE ERADICATION OF PLAGUE FROM LARGE CITIES.\*

BY CHARLES W. VOGEL, M. D., REEDY ISLAND QUARANTINE, DEL.

Passed Assistant Surgeon, United States Public Health and Marine Hospital
Service.

On account of the prevalence of plague in epidemic form in Manchuria at the present time, it occurred to the writer that a short article anent the title of this paper might be of interest.

The bacteriological and clinical aspects of plague may be dismissed with a reference to the various text-books on medicine and bacteriology.

The eradication of plague from urban communities may be succinctly stated to be dependent upon two main factors, the destruction of the rat population and the rat proofing of all buildings of every description.

This statement is quite simple, but the practical application of the measures designed toward rat destruction is a very difficult matter at times. The experience of the Public Health and Marine Hospital Service in its antiplague campaign in San Francisco in 1907 and 1908 demon-

\* The New York Medical Journal for March 11, 1911.

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strated that a most potent factor in carrying out antiplague measures is an aroused, intelligent, public opinion. If the public understands thoroughly what plague is and why the various measures are instituted, there will be much less obstruction to the work of the sanitary officer. On this account it is a very good plan to have the sanitary officers deliver popular lectures to the various civic bodies, as a very important part of the campaign. In these lectures the nature and history of plague should be dwelt upon, laying especial emphasis upon the intimate relation which rat plague bears to the prevalence of human plague. The co-operation of the city government in all of its departments is absolutely necessary, in order to arrive at results. Special ordinances must be passed through councils from time to time as conditions may require. The measures directed toward the destruction or diminution of the rat population may be stated to be as follows, viz: 1, trapping of rats; 2, poisoning of rats; 3, deprivation of food supply of rats; 4, destruction of breeding places of rats; 5, rat proofing of dwellings, outhouses, yards, etc.; 6, rat proofing of stables, markets, bakeries, etc.; 7, rat proofing of warehouses and docks; 8, rat proofing of all sewers.

The accomplishment of some of these measures must necessarily depend on the carrying out of different details under different conditions, but the principle of action remains always the same. It will be seen at a glance that the carrying into effect of some of these measures might offer almost insurmountable difficulties. The expenditure of time and money is necessary in order to properly rat proof buildings, etc., in a city, but this work can continue indefinitely as a settled policy after the more immediate work of fighting the plague epidemic has terminated.

So also the systematic destruction of rats should be prolonged indefinitely. Especially in seaports is the latter measure of the greatest importance. If a concerted effort could be made in all the principal seaport cities of the world towards a prolonged systematic destruction of rats, the danger of an epidemic of human plague in any of these cities would be reduced to a minimum. It was shown conclusively in the campaign in San Francisco that the cases of human plague decreased as the percentage of infected rats decreased, and the percentage of infected rats decreased as the number of rats trapped increased, showing that diminution of the rat population almost certainly causes a diminution in the percentage of infected rats. For trapping of rats two forms of trap were mostly used, the large cage trap and the snap trap.

The rat is a very cunning animal, and it was found necessary to change the style of trap used at a certain location from time to time, as also the method of placing the trap and the bait used. Cheese, bacon, and grain seemed to be the best bait. Fish heads and occasionally cabbage leaves also acted well. The cage trap has the advantage of, at times, enticing a large number of rats into one trap, as the rat is a very gregarious animal when in health. The cage trap will act particularly well if the first rat trapped happens to be a female, thereby luring the males to their doom. The snap trap of course can only trap one rat at a time, but it is very useful at times, especially after the rats have become suspicious of the other form of trap. The rat has quite a large amount of curiosity, and on this account he sometimes is caught in the snap trap while he is examining the same. Smoking of traps from time to time is very important, as after a large number of rats have been trapped, the trap retains the odor of the rodent, thereby warning other rats away.

Our experience in San Francisco caused us to rely on the mineral poisons almost exclusively, as we found that the so called biological poisons were useless. Danyz virus, rattite, azoa, and a number of others of the biological poisons on the market were given a fair trial, but with very indifferent results. Danyz virus, if perfectly fresh, is probably active, but it would be impracticable to use it on a large scale, as it would require a large laboratory to produce the quantity required. Phosphorus and arsenic paste were used almost exclusively in the work in San Francisco. Any one of a number of phosphorus pastes on the market may be used, but great care must be exercised to guard against the possible occurrence of fire. For this reason arsenic paste was mostly used in San Francisco. The paste contained about fifty per cent white arsenic, with a base of corn meal and cheese made into a paste with some suitable menstruum. This was spread on cubes of bread and placed near rat holes and in rat runs.

Of course the estimation of the number of rats killed by poison is always more or less of a guess. In trapping one knows exactly how many rats are being caught, but then poisoning surely destroys a goodly number. So that it should always be employed in conjunction with the other measures of deratization.

The destruction of rat breeding places is very important. All piles of lumber, brick, or any similar material should be so placed that at least two feet of space remain between the lower surface of the pile and the ground. It should also have no interstices in the mass to offer hiding places for rats. All wooden areaways, boarded back yards, or boarded floors of basements should be torn up and replaced by concrete. In many instances in San Francisco nests containing litters of a half dozen or more of young rats were found in this way. So that we destroy the vermin in the easiest manner possible in this way and preclude the possibility of many new sources of increase in the rat population.

The deprivation of the food supply of the rat will depend almost solely on the efficiency with which street cleaning, garbage collection and disposal, and general sanitary supervision of vacant lots is conducted by the constituted authorities. All garbage receptacles should be made of metal with tight fiting metal covers and kept covered at all times. This should be rigidly enforced by stringent ordinances. The garbage should be removed frequently and disposed of by incineration. Garbage dumping grounds in the outskirts of the city are a relic of the past and should be eliminated as rapidly as possible. These dumping grounds furnish an ideal rat harbor and very largely nullify the work of deratization that may be going forward in the city proper. Strict regulations should be enforced with regard to the prevention of refuse being allowed to lie about in markets, bakeries, etc.

Rat proofing can best be carried out by making the basements of all new constructions of concrete, the floors and the walls to a height of one foot above the ground to be so constructed. All stables, markets, warehouses, etc., with wooden floors should have the same replaced by concrete. All docks should be built in such a manner that they are rat proof. The details of construction would have to be determined by the circumstances in each case.

At seaports all vessels from plague infected ports should be required to have rat guards or funnels on the hawsers at all times while moored to the wharf and to lay off from the wharf at night. The holds of such vessels should be treated with sulphur dioxide several times a year for the destruction of rats.

Now a word as to the danger from the rat flea and other varieties of

fleas on the common domestic animals. To guard against possible danger from rat fleas on domestic animals, the fur of these animals should be frequently well treated with pyrethrum powder, when any fleas which may be present are stunned and they can then be collected from the fur and burned. It is the opinion of the writer that the rat flea is comparatively of little consequence provided the rat, its host, is vigorously exterminated. All flea nests should be thoroughly drenched with crude carbolic acid or kerosene.

Every case of human plague should be immediately isolated in a special plague hospital.

The measures discussed in this paper comprise, it is believed, all the measures which would ordinarily be instituted in a campaign of eradication of plague from a city.

## VALEDICTORY, 1911.

By DR. J. F. SHEA, '11.

Four years ago the members of this graduating class, instilled with high medical thought and eagerness to do good for mankind, took up the study of medicine.

Our course of study has been completed; to the world we are members of the profession; in our hearts there is that same feeling that prompted us to take up the pursuits realized, but not fulfilled.

Gentlemen of the Faculty, as spokesman for my class, I wish to extend to each of you our grateful appreciation for your untiring efforts in our behalf. You received us four years ago in the rough, and in the short time that has elapsed you have endeavored faithfully to mould us in the likeness of doctors. Time alone will show in just how far you have succeeded.

Each of us who sit around this board tonight have you to thank for the honor and privilege. It is up to us who are soon to face the world to bring honor to the college and those connected with it by our example.

This is not a time to "knock," rather it is a time to be merry, but I hardly think it amiss or out of place to drop a few hints in passing which perhaps will fall on fertile ground and be of help to those who are yet to learn the tribulations as well as pleasures of the medical profession.

Has it ever occurred to you that three years should be sufficient time to measure a man's capabilities and possibilities? Certain it is that if close observation of a man for three years fails to give you an idea of the man's worth, an additional year will hardly do what three years have failed to do. I am sure you follow my reasoning. The thing that every year mars the real pleasure of the graduating class is the failures. Don't you think that it would be possible to make your standard so high for the first three years that a very weak man could not slip into the senior year?

My idea is this, the teaching faculty should be so acquainted with a man that his worth and qualifications should not depend upon the final examinations of his senior year; in other words, if he is weak, he should be notified to that effect and not allowed to take fourth year examinations. How pleasing, how elevating and how grand it would be if on the night of returns, everyone would be given a satisfactory card, for who of us has not had his rejoicing turned into sadness by the failure of a dear friend, nay, perhaps even more, a roommate of four long years.

Gentlemen, this matter deserves consideration, for it strikes me that it is almost as much reflection upon the college who fails a man in his senior year as upon the poor unfortunate who fails.

We hear much on medical ethics, but so far you have only given us a theoretical course. It has not been worked out practically, and we as a class leave you tonight with the sincere hope that through our example and frankness in all questions we will be of some real service to you.

Gentlemen of the Faculty, my fondest hope is that of this class every man will prove to be a bright particular star in one large constellation. We wish you success and consecrate ourselves ever to one promise: That whatever of life's honors we attain, we will bear the trophies, in thought at least, to you. In this farewell we wish you each "Godspeed."

My dear classmates, after four years' association, we must part to enter into the world with the motto that "When one sets out to lead a grand life, man cannot interrupt him, God will not." Let not our aim be to achieve wealth, but rather to lead a life of self-sacrifice and thanksgiving.

Classmates, it is hard to find words fitting to express the sadness within us when we reflect that this occasion is our final gathering. During our course many friendships have been formed, courtesy and consideration has been the feeling amongst us; let us as we pursue our life's work carry

these same thoughts, and let our actions always be as keen and alert as they have been.

We must say farewell. The good will that each has for the other and the spirit of friendship that exists lay a heavy tax on our emotions as we say the word "Farewell." No longer shall we interchange morning greetings, no longer shall we have the opportunity to ask each others advice and assistance, but our common wish is that each one of us may be successful, happy and exemplifiers of the medical profession.

June 6, 1911.

#### HUNTINGTON, W. VA., April 30, 1911.

Dear Dr. Brack.—Am enclosing a little circular that may be of interest to you inasmuch as you helped to start me on the road to the construction of the thing which it illustrates. The cuts do not do the little place justice, though they are fairly good. We have been having a nice run of work and the place has been fairly full most of the time. Wish you could come out and make us a little visit. I know there isn't any one that would be more delighted to see you than we would. Dr. Guthrie leaves for Rochester (to attend the Mayo clinic for three weeks) the middle of this week and that will mean "Steeny" will have to hustle some to keep up with the work, but see if he cares. Hope you are feeling lots better than you were the last time I heard from you. Remember me to the Boy and Mrs. Brack and her sister also. I certainly would like to drop in for a little quiet game of cards some evening, but we can't always do just what we wish to. Drop me a line whenever you find the time for I am always glad to hear from you. I remain,

Very sincerely yours,

STEENY.

WARM SPRINGS, MONTANA, May 15, 1911.

Dear Dr. Brack.—Enclosed you will find \$2.00 to pay my subscription to the JOURNAL. I enjoy reading the JOURNAL very much as it is the only means I have of hearing from the boys.

With best wishes I remain,

Very sincerely,

H. A. BOLTON.

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## THE JOURNAL

#### OF THE ALUMNI ASSOCIATION

OF THE

## COLLEGE OF PHYSICIANS AND SURGEONS, BALTIMORE.

#### THE ALUMNI ASSOCIATION MEETING.

The annual meeting of the Alumni Association was held in the large amphitheater in the college building, Monday, June 5, at 8.30 p.m. The attendance was very gratifying as many out of the town alumni were present. The classes of '91 and '96 were of course much in evidence and the boys reminisced to their hearts' content. Dr. W. H. Delaney, who had engineered the reunion of '91, was considerably disappointed that many of his classmate's who had promised to attend the meeting were not present. Dr. Jno. O. McReynolds, who was to have delivered one of the addresses, was detained by business connected with the Southwestern University. The State of Texas has recently appropriated a large sum of money for the state university and Dr. McReynolds is dean of the medical department.

The re-union of '96 was in the hands of an active committee consisting of Drs. H. G. Beck, A. W. MacDonald, G. Thieme, Albertus Cotton, H. C. Knapp, Wm. Wolfe and Jesse Coggins. To these gentlemen and to Dr. Delaney, '91, belong the credit of bringing the men together.

The members of '91 present were Drs. James Gass, C. Hampson Jones, D. C. Trach, W. A. Zellers, J. Percy Wade, O. L. Perry, Percival Lantz, J. E. Glenn, Geo. W. Poovey and W. E. Delaney.

The members of '96 were:

Cook, Dr. Hugh F., Newark, N. J. Thieme, Dr. G. C., Baltimore, Md. Wolf, Dr. Wm. B., Baltimore, Md. Williams, Dr. Pearl, Providence, R. I. MacDonald, Dr. A. W., Balto., Md. Harper, Dr. F. W., Irvona, Pa. Johnson, Dr. J. M., Huntington, Pa. Kisner, Dr. A., Hellertown, Pa. Lacy, Dr. J. W., Lisbon, Md. Neuth, Dr. Jno. H., Pittston, Pa. Payne, Dr. J. B., Clarksburg, W. Va. Coops, Dr. F. H., Bridgeport, Conn. Schaefer, Dr. J. E., Cogan Sta., Pa. Arnold, Dr. F. S., Washington, D. C. Knapp, Dr. H. C., Baltimore, Md.

Coggins, Dr. Jesse C., Laurel, Md. Cotton, Dr. A., Baltimore, Md. Mitchell, Dr. G. W., Baltimore, Md. Requardt, Dr. W. W., Baltimore, Md. Beck, Dr. H. G., Baltimore, Md.

Dr. Standish McCleary presided in the absence of the president, Dr. E. A. Bowerman, '95, who was unable to be present. Upon motion the routine business was suspended, with the exception of the election of officers. Dr. Frank H. Coops, '96, of Bridgeport, Connecticut, was elected president for the year: Dr. A. C. Gillis, '04, vice-president; Dr. W. H. Hobson, '10, 2d vice-president; Dr. H. Fleckenstein, '04, secretary; Dr. Chas. E. Brack, '95, treasurer; Drs. H. K. Fleckenstein, A. Ullman, '02, and W. D. Wise, '06, banquet committee; Drs. Wm. S. Gardner, '85, John Ruhräh, '94, and Chas. E. Brack, '95, publication committee.

The treasurer reports receipts for 1910, \$870.40; balance in treasury, 1909, \$80.39; expenses \$911.32, leaving a balance, June 1, \$39.47.

Dr. Frank H. Coops, introduced by Dr. McCleary, delivered an interesting address. He dwelt largely upon the improvement and expansion of the college since 1896 and the general excellence of the course of instruction and the present teaching staff. He made a strong plea for loyalty on the part of our alumni. The chairman after thanking Dr. Coops for his address and voicing the appreciative sentiments of the meeting, called upon Dr. W. E. Delaney, Dr. James Gass, '91, Dr. Louis F. Ankrim, '86, and several other alumni, who responded most happily. The meeting then adjourned to the lower class-rooms where a lunch and smoker had been arranged for. The class of '96 and guests later repaired to The Baltimore Athletic Club, where further entertainment had been provided. Swapping stories and reminiscences of former college days kept the boys up until the wee hours.

On Tuesday morning the alumni were conducted through the new hospital building, which is in every respect thoroughly up-to-date; it represents the combination and modification of ideas and impressions obtained by a committee of the Sisters of Mercy, who had visited every large and modern hospital in the east and middle west before the present building was planned. Dr. N. G. Keirle and his assistants then demonstrated the Pasteur treatment. Dr. A. G. Rytina explained and demonstrated the administration of salvarsan on a number of patients. At noon

the class of '91 journeyed to Catonsville where they were delightfully entertained by Dr. Percy Wade, '91, at the Maryland State Asylum. The '96 boys and guests steamed through the harbor on a chartered tug and landed at the Quarantine Station where they were received by Dr. Richardson, the quarantine officer, and Dr. Clarke, his assistant. Luncheon was served in the open at Quarantine and several group photographs taken.

#### THE COMMENCEMENT.

The annual commencement was held at the Lyceum at 8 p. m. The alumni were provided with seats on the stage, and, clad in cap and gown, presented a fine appearance. Rev. Dr. John Roach Stratton made the oration. Prof. A. C. Harrison awarded the prizes and Prof. Charles F. Bevan conferred the degrees.

The banquet at the Hotel Rennert followed. One hundred twenty-one members were present. Prof. Wm. Royal Stokes was a royal toast master and introduced the speakers with appropriate quotations. Dr. Wm. E. Delaney, in the absence of Dr. A. B. Straight, responded for the class of '91. He claimed as the chief characteristic of '91 at the time of graduation an abundance of hair and whiskers; he intimated that the custom had changed, the present graduating class was clean shaven and had little hair. He could not determine the significance from a medical standpoint, but the class of '91 was the best class that had ever graduated from the P. & S. He also said that after the commencement in 1891, eight men from Pennsylvania travelled home together in a special car and thought much of themselves. They organized an Oriole P. & S. medical society on the train but nothing was ever heard from this society. Dr. Delaney paid a tribute to the achievements of Dr. Jno. O. McReynolds, the honor man of '91, and to Dr. James Gass, the second prize winner. He also recommended the taking of a post graduate course every five years.

Dr. Alburtus Cotton responded for '96 in the absence of Dr. Frank Barnes. He introduced the members present with comments upon their achievements and personal characteristics.

Dr. John W. Chambers responded for the faculty. He said that it was as much as he could do to speak for himself much less for the faculty. Dr. John F. Shea responded for the class of '11. Dr. Wm. S. Gardner

on behalf of Dr. Harry Friedenwald, who is at present abroad, presented a bound volume, containing the history of the members of '86 with a photograph of each member. Dr. C. Hampson Jones, an honorary member of '91, reviewed college doings in 591. Rev. Mr. Stratton closed the exercises by relating several anecdotes.

#### HONORARY DEGREES.

Quite a number of the members of our Faculty have been honored by having honorary degrees conferred upon them by various universities and colleges. Among those who have recently been so singled out, are Dr. N. G. Keirle, who received the degree of Doctor of Laws from Dickinson College, Dr. Albertus Cotton who received the degree of Master of Arts from the Ohio State University, and Dr. A. C. Gillis who received the degree of Master of Arts from Loyola College for post-graduate work in psychology. Rock Hill College, Maryland, has conferred the degree of Master of Arts upon Dr. Alexius McGlannan.

#### THE MERCY HOSPITAL ADDITION.

The new fireproof addition to the hospital is practically completed and will soon be ready for patients. There are well-lighted mosaic halls, with various suites of apartments, opening out onto airy balconies, which will tend to hasten the convalescence of the occupants. The up-to-date arrangement of the wards, well-lighted and ventilated, the sanitary terrazo floors, the large openings from floor to ceiling out onto the porches is another feature. The children's ward especially, with its detention apartments for suspected cases of infection, also the day room and the commodious porch for out-door treatment, is up-to-date in all requirements.

The new operating rooms on the fifth floor add a much needed feature, there being a central room with adjoining rooms arranged for tonsilectomies, etc., a sterilizing room, anaesthetic room, dressing rooms, etc. The pergola and solarium opening out from the fifth floor should prove a boon to the many who remain after operations.

A beautiful chapel is a part of the new structure. The stairs throughout are Tennessee marble, the balustrade of metal, the hand rail of mahogany. A new electric elevator is an added convenience. The refrigerator system throughout the building is supplied from the ice plant on the premises. The dynamos for manufacturing the electric light and power, with the silent call system for the doctors, make this new addition compare favorably with the latest ideas of hospital conveniences.

Three large boilers supply the heat throughout the buildings, these with the incinerator for refuse and the sterilizer for mattresses, etc., are all newly arranged. The new laundry has all the recent improvements with electric power at command. A new kitchen, having a floor of Tennessee marble, a monster gas range, steam trays for food, with all the other accessories of modern convenience, is a model of completeness. There is also a diet kitchen for the instruction in dietetics and the careful preparation of special food for the sick, which is beautifully equipped. The basement floor is arranged for dining halls for the nurses.

#### THE BACILLUS CLUB MEETING.

On Wednesday evening the Bacillus Club met at the Hotel Junker and held an old time bacillus meeting. This club was organized in 1897 at the college by the consolidation of the Samstagnacht Verein and the Brannigan Sons of Purity. Sixteen members of the original club were present and during the dinner the secretary read the minutes of the interesting meetings which the club had enjoyed in the days gone by, amongst which may be mentioned: When Dr. Ruhräh had been sent to Paris to bring rabbits for the Pasteur department; when Little Egypt (Melvin Rosenthal) danced before the club and was arrested by Capt. Chapman (Dr. Jacobus Halper); when the club journeyed to Dr. Fort's place and indulged in field sports, and when Dr. Pearl Williams and Carswell went to Germany on the Willehad. After dinner the roster of the club was read and we remembered the absent and those members who are no more, Dr. N. G. Keirle, Jr., and Dr. W. Vinal. Several contributions in verses written by Dr. Keirle had been preserved and were read. Flashlight pictures of former meetings were also exhibited. The club then sang the club song "Casey would waltz with the strawberry blond" this was followed by "Down on the Little Pedee," "Roger and the Troubadour," etc. For the first time in the history of the club the secretary did not lose the music on the way home.

#### HOSPITAL APPOINTMENTS.

More than half of the graduating class of this year received hospital appointments. Quite a number of these were obtained as the result of competitive examination.

Dr. C. J. Baumgartner, Hebrew Hospital, Baltimore.

Dr. A. Burton Eckerdt, Mercy Hospital, Baltimore.

Dr. Howard E. Harman, Mercy Hospital, Baltimore.

Dr. Jno. F. Hogan, Mercy Hospital, Baltimore.

Dr. Audrey F. Lawson, Mercy Hospital, Baltimore.

Dr. J. E. Marschner, Maryland Lying-in Asylum, Baltimore.

Dr. Fred. J. Morrison, Hebrew Hospital, Baltimore.

Dr. Thos. J. Roche, Bridgeport General Hospital, Connecticut.

Dr. John F. Shea, Bridgeport General Hospital, Connecticut.

Dr. B. H. Swint, St. Joseph's Hospital, Baltimore.

Dr. J. Thorkelson, Mercy Hospital, Baltimore.

Dr. Caldwell Woodruff, Mercy Hospital, Baltimore.

Dr. C. W. Zurcher, Mercy Hospital, Baltimore.

Dr. Waitman F. Zinn, Mercy Hospital, Baltimore.

Dr. Norris B. Whitcomb, Mercy Hospital, Baltimore.

Dr. Paul Rider, Mercy Hospital, Baltimore.

Dr. Wm. T. Gocke, Mercy Hospital, Baltimore.

Dr. J. W. Callahan, St. Francis Hospital, Hartford, Conn.

Dr. Horace W. Kohler, York City Hospital, York, Pa.

Dr. Karl Allison, Youngstown City Hospital, Youngstown, Ohio.

Dr. J. W. Hughes, Providence Hospital, Washington, D. C.

Dr. Edw. J. Pinkus, St. Mary's Hospital, Hoboken, N. J.

Dr. B. H. Cooper, Nanticoke Hospital, Luzerne County, Pa.

Dr. Geo. P. Waller, Gouverneur Hospital, New York City.

Dr. Philip Heyman, Newark City Hospital, Newark, N. J.

Dr. R. E. Stack Kelley, St. Elizabeth Hospital, Boston, Mass.

Dr. Frank L. Jennings, Mercy Hospital, Baltimore.

Dr. J. B. Kilbourne, Woman's Hospital, Baltimore.

Dr. Robert J. McDowell, General Hospital, Rochester, N. Y.

Dr. K. H. Trippett, Mercy Hospital, Baltimore.

Dr. F. H. Hutchinson, Mercy Hospital, Baltimore.

#### THE CLASS OF 1911.

The members of the graduating class are as follows:

Eckerdt, A. Burton....Maryland.
Edmondson, Henry T.....Georgia.
Flynn, John F....Connecticut.
Gano, Chas. H....Pennsylvania.
Gocke, Wm. T....West Virginia.
Gautier, Claude V...West Virginia.
Harman, Howard E....Ohio.
Harmer, Chas. G....New York.
Hamilton, E. St. C...West Virginia.

Hanifin, John F	Massachusetts.
Hanellin, Nathan	New York.
Heyman, Philip	New Jersey.
Hogan, John F	Connecticut.
Hutchison, F. H	Connecticut.
Hughes, J. W	
Hall, Archie C	West Virginia.
Jennings, Frank L	
Kilbourne, Jos. B	
Kohler, Horace W	
Kahle, W. D	West Virginia.
Kelley, R. E. S	
Kocyan, Jos. J	
Lawson, A. F	West Virginia.
Lawry, Oram R	. Massachusetts.
Lussier, Waldo J	Rhode Island.
Marchner, J. E	
Mutchler, H. R	
Morrison, Fredk. J	Connecticut.
Miller, Herman S	Delaware.

Makin, John BNew Jersey.
Michel, IsidorNew York.
Mendelevitz, JacobNew York.
McDowell, Robert JNew York.
O'Connor, John VRhode Island.
Pinkus, Edward JMexico.
Rider, PaulWest Virginia.
Roche, Thomas JRhode Island.
Shea, John FMassachusetts.
Swint, B. HWest Virginia.
Sorensen, Antone CUtah.
Trippett, K. HWest Virginia.
Thorkelson, JDelaware.
Waller, Geo. P., JrCalifornia.
Whitcomb, N. BNew York.
Woodruff, Caldwell .North Carolina.
Williams, Louis VPennsylvania.
Zurcher, C. WOhio.
Zinn, Waitman FWest Virginia.
ZIIII, Waitman F Wood VII

The college prizes were awarded to John F. Shea, of Massachusetts, first prize; C. J. Baumgartner, of Georgia, second prize; Paul Rider, of West Virginia, third prize; Louis V. Williams, of Pennsylvania, fourth prize.

Those receiving honorable mention were as follows: Claude V. Gautier, of West Virginia; J. Thorkelson, of Delaware; N. B. Whitcomb, of New York; J. W. Callahan, of Connecticut; Frank L. Jennings, of Maryland; B. H. Swint, of West Virginia; F. H. Brown of West Virginia; Thos. J. Roche, of Rhode Island.

### MERCY HOSPITAL TRAINING SCHOOL COMMENCEMENT.

The graduating exercises of the Mercy Hospital Training School were held on May 29, at 8 p. m., in the addition recently built.

The Dean of the Faculty of College of Physicians and Surgeons, Dr. C. F. Bevan, awarded diplomas to the following young ladies: Mary Elizabeth Brady, Laura May Schroeder, Elizabeth Andrews Moore, Salada Bell Kohler, Mary Jane Harris, Mary Anne Hurley, Agnes Teresa Lynch, Katherine Malvina Numbers, Anne Genevieve Hill, Ethelean Jane Cunningham, Sara Catherine Quinn, Alva Gertrude Coleman, Rose Mary Russell, Margaret Drea Hindenack, Sarah Valeti Case, Della Case, Marian Imelda Looby, Beulah May Wakeman. The gold medal for excellence in theoreti-

cal and practical nursing was awarded to Miss Anne Genevieve Hill. Monsignor William T. Russell and Colonel John T. Morris congratulated the class on their success in some well chosen remarks.

The Mercy Hospital Alumnæ Meeting was held the next day, when the recent graduates were admitted as new members. The officers of the preceding year were re-elected: Miss Martha Hartman, president; Miss Sadie Roe, vice-president; Miss Emma Kinhart, treasurer; Miss Sara Ward, secretary.

The Alumnæ are deeply indebted to Dr. Rytina for his clear exposition of the Salvarsan treatment, delivered to the members on this occasion.

## MEMBERS OF THE CLASS OF '86 WHOM WE CANNOT LOCATE.

Brothers, W. P. Caldwell, Geo. B. Chappell, W. A. Chisolm, James Emerson. Connelly, Joseph P. Coyle, Felix A. Fore, James H. Gosh, Lloyd D. Hammitt, Sothoron B. Hunter, H. M. Husler, John T. Jones, W. Preston. Kimball, Ernest D. Kirkpatrick, Edwin. Krystall, Berthold E. Ledbetter, Jno.

McAlpine, William.

Montgomery, James Eddy. Powell, James H. Reading, Jno. M. Reece, J. Montgomery. Schell, M. S. Schrecengost, L. Curtis. Seaton, Leander. Shoemaker, David E. Summer, G. B. Vees, Chas. H. Walker, James T. Watson, Wm. Windsor, S. J. Wogefarth, J. A. W. Wolfe, W. Young, John D. S. Wise, James A.

Kindly address Dr. Chas. E. Brack, 500 E. 20th St., if you have any knowledge about the men on this list; such information will be greatly appreciated. Dr. Harry Friedenwald, '86, is greatly interested in obtaining information about the members of his class.

#### THE MERCY HOSPITAL FUND.

We desire to voice our appreciation of the response many of our alumni have accorded to the appeal for the Mercy Hospital fund. Some of our men have contributed very generously. A list will be published in a later issue. We are about to make a concerted appeal to the individual classes

so that the moneys contributed can be identified more accurately with the alumni association. We do not ask you for a definite amount, but will accept gratefully any sum you feel disposed to give.

The close alliance between the college and the Mercy Hospital is perhaps not sufficiently understood by our alumni. In appealing to you for an increase of your interest and loyalty and your patronage of the New Mercy Hospital, which most of you have known as the City Hospital, we beg of you to bear constantly in mind the fact, that though the College of Physicians and Surgeons and the Hospital as corporate bodies are separate institutions, yet for all essential purposes they form one grand and glorious institution; both are the result of evolution and from small beginnings have developed into very large enterprises and a credit to their officers and to you as alumni.

In the inception of both corporations the closest kind of an alliance was established between the two bodies. The College is supreme as a teaching organization and furnishes in *perpetuity* the medical and surgical services to the Hospital and has the use of its material for teaching purposes. In the nursing and all the details of hospital management the supreme authority is vested in the other corporation. The two bodies work in such absolute harmony that their interests are identical and the purposes of each and the great growth and development of both has brought about the construction of the present hospital and its magnificent addition.

Our alumni can and should take a just pride in this noble work and should use every endeavor to support and aid our alma mater, the faculty and the hospital management to equip this new and modern institution in a worthy manner.

### '75, '92, AND '97 CLASS REUNION NOTICE.

The class of '75 has deferred its reunion until 1912. The time for preparation for this year's reunion was entirely too short to insure a successful meeting. Dr. Jno. D. Blake, of Baltimore, and Dr. Luther H. Keller, of Hagerstown, are going to take the matter of this class reunion in hand and we are assured that the men of '75 will make every endeavor to be present.

The class of '92 has a number of its members in Baltimore and with a good working committee will be able to organize with good success. Dr.

H. H. Hayden, Dr. H. Lee Franks, Dr. Wm. E. Miller, Dr. E. A. Munoz, Dr. W. W. Frames, Dr. Milton D. Norris and Dr. L. E. Conradi represent '92 in this city.

'97 has only two of its members in Baltimore—Dr. A. S. Gage and Dr. E. J. Russell.

Dr. Brack would greatly appreciate it if the members of '75, '92, and '97 will communicate with him at once regarding the class reunions. Unless a large number of the members of the classes mentioned are interested it will not be advisable to arrange for the meetings.

#### A TRI-STATE CHAPTER.

A number of the graduates of P. & S. met at the home of Dr. H. B. Sheffield, 127 West 87th street, New York, on May 27, for the purpose of perfecting an organization of the Tri-State Chapter (New York, New Jersey and Connecticut) Alumni College of Physicians and Surgeons of Baltimore. A constitution was adopted which declares that "This society is established for the purpose of fostering the social and professional relationship of the alumni, to elevate the standing and to cherish and perpetuate the memories of our Alma Mater." The following officers were elected: President, Dr. W. E. Fitch, '91, 345 West 145th street, New York; first vice-president, Dr. Wm. J. A. O'Hara, '93, 361 Barnum ave., Bridgeport, Ct.; second vice-president, Dr. John H. Carmen, '81, 602 Crescent avenue, Plainfield, N. J.; secretary, Dr. J. G. Callison, '09, 601 West 135th street, New York; treasurer, Dr. H. B. Sheffield, '95, 127 West 87th street, New York; librarian, Dr. Arthur C. Palmateer, '06, 1239 St. Lawrence avenue, New York. The executive committee includes the above officers, with one elected member from each of the states represented. These are: For New York, Dr. Frederick M. Luther, '80, chairman, 1 West 34th street, New York; for New Jersey, Dr. Otto C. Thompson, '06, Cassvill, N. J.; for Connecticut, Dr. D. J. McCarthy, '07, Bridgeport, Ct. Meetings are to be held on the second Wednesday of October, December, February and May of each year, and the chapter is to be represented at the annual Alumni Association meeting by the president or first vice-president. There are more than 100 alumni of P. & S. residing in the states of New York, New Jersey and Connecticut, and most of these reside in the territory tributary to New York City. Any graduates

of P. & S. residing in these three states who failed to receive a notice of the first meeting will please send their name and address to the secretary.

#### THE CHARLES G. HARMER PRIZE.

With a view of stimulating on the part of the student an interest in research work, especially as it relates to the history of medicine, Dr. Charles G. Harmer, '11, has offered a prize of \$25.00 for the best essay on the subject of the history of medicine. The following rules must be observed in the competition:

- 1. All students of the final year are eligible to compete.
- 2. Essays must be original.
- 3. Essays submitted for competition must be legibly signed with a pseudonym and must be accompanied by a coupon with the name signed. such coupon must be enclosed in a sealed envelope on the outside of which is written only the pseudonym of the competitor. This envelope is not to be opened until the award is made.
- 4. The judges reserve to themselves the right of withholding the prize if the rules of the competition have not been complied with, or if in the opinion of the judges the essays are of insufficient merit. They also reserve the right to publish at such time as they deem fit any of the essays submitted.
- 5. The prize winning essay must be deposited in the keeping of the college librarian in its original manuscript form, being subsequently duly autographed by its author.
- 6. All essays must be written upon one side of the sheet and preferably upon typewriter paper  $8\frac{1}{2} \times 12$ .
- 7. Essays and correspondence thereon to be addressed to the College of Physicians and Surgeons, Baltimore, and marked Prize Essay Competition.
- 8. And infringement of the above rules will disqualify a competitor.

  The decision of the judges shall be final on all questions under these rules.

Coupon:	Pseud				•	 			•	٠			•	
	Full	name									•			
	Addr	ess	 		 									

### Dbituary.

Dr. Frederick T. Robinson, '93, of Brooklyn, Md., died in the Johns Hopkins Hospital, April 10, aged 43.

Dr. Henry Kunkel, '89, a member of the American Medical Association and American Academy of Medicine, died at his home in Kingston, Pa., April 26, from chronic bronchitis, aged 49.

Dr. George S. Luck, '73, a Confederate veteran, and a member of the Roanoke (Va.) Academy of Medicine, died at his home in that city, March 19, from cerebral hemorrhage, aged 64.

Dr. Robert A. Walker, '82, a member of the Medical Society of the of the State of Pennsylvania, of Rockville, died at the home of his sister in Wilkinsburg, March 29, from cancer of the intestines, aged 54.

Dr. William E. Norton, '93, of Savannah, a member of the Medical Association of Georgia, local surgeon for the Seaboard Air Line and the Savannah Electric Company, died at Cornwall-on-the-Hudson, N. Y., March 28, from pneumonia, aged 40.

Dr. Alfred L. Wolffe, '75, died at his home in Roanoke, Va., on March 1, He was born in Rockingham County, Va., December 26, 1853. After finishing his academic education in the public schools, he studied medicine at the college. He was a member of the Medical Society of Virginia, and for several years one of the surgeons to the Norfolk and Western Railway. He is survived by his widow, who was Miss Elizabeth Milnes. The Roanoke Academy of Medicine adopted resolutions on the death of Dr. Wolfe.

### Personal Motes.

Dr. William Veenstra was married April 19 to Miss Theresa Atherton, daughter of Mr. and Mrs. Frederick L. Atherton, of Paterson, N. J.

Dr. W. L. Babcock, '93, is president of the American Hospital Association, the next meeting of which will be in New York City. Dr. Babcock is practising in Detroit, Mich.

Among recent visitors at the College we note: Dr. Chas. F. Abbott, '03, Elmira, N. Y.; Dr. M. R. Stone, '08, Parkersburg, W. Va.; Dr. Edw. McGinty, '04, Pittston, Pa.; Dr. Louis Stick, '00, Worcester, Mass.; Dr.

H. G. Steele, '03, Keystone, W. Va.; Dr. H. W. Uffelman, '07, Windsor, Pa.; Dr. A. W. Brinham, '05, Scalp Level, Pa.; Dr. E. T. Quinn, '10, Jenkinstown, Pa.; Dr. E. S. Stambaugh, '10, Thomasville, Pa.; Dr. J. C. Madara, '98, Ridgely, Md.

DR. MARVIN ROY STONE was married Monday, May 16, to Miss Susan Priscilla Montgomery, daughter of Mr. and Mrs. James M. Montgomery of Portsmouth, Va. Dr. and Mrs. Stone will make their home at  $619\frac{1}{2}$  Market street, Parkesburg, W. Va.

DR. JOHN H. DOYLE, '02, who practiced at Grafton for a number of years, gave up his practice at that place, took a post-graduate course at the College, and, after an extensive trip abroad, has returned to settle in Fall River, Massachusetts, where he will specialize in diseases of the nose and throat.

DR. J. A. GUTHRIE and DR. J. H. STEENBERGEN have opened a private hospital in Huntington, W. Va., which is called the Guthrie-Steenbergen Hospital. This is located in a quiet section of the city and contains modern operating rooms, sun parlors and all the modern appliances for studying and treating disease. (See Correspondence.)

Dr. Francis J. Snyder on his return from an extended trip to Cuba and other interesting places spent quite some time at the College engaged in doing special work. We were delighted to have the genial doctor with us and were sorry to have him leave. It will be interesting to his friends to know that Dr. Snyder is forming a stock company to control the sponge market. The project is a most interesting one and if it works out only one tenth as well as the doctor hopes, it will make a fortune for every one who has taken up the proposition.

In addition to the boys of '91 and '96 there were present at the alumni meeting: Drs. Chas. W. Vogel, '95; J. W. Mankin, '06; A. C. Blair, '01; D. C. Patterson, '06; F. E. Roe, '10; H. H. Johnson; S. T. Lowry, '01; Geo. A. Strauss, '83; Geo. A. Strauss, Jr., '08; Thos. F. Keating, '10; T. W. Bailey, '86; H. Lees Franks, '92; J. M. Hoag, '02; Alfred Gundry, '94; D. J. Leatherman, '86; Lois F. Ankrim, '86; J. A. Kilbourne, '97; D. P. Frey, '89; A. B. Lyons, '06; Homer S. Brown, '08; C. G. Hildebrand, '81; E. E. Roe, '07; Jno. G. Stiefel, '01; Samuel Schmidt, '01; Wm. J. Schmitz, '07; H. H. Esker, '06; A. G. Barrett, '00.

#### Correspondence.

#### REUNION OF CLASS OF '75.

HAGERSTOWN, MD., May 25, 1911.

My dear Dr. Brack.—A rush of business has prevented me from writing you as to the reunion of '75. I have had letters from four saying they would be present, but the rest were all so uncertain and the time was so short, I thought best to advise the calling off of the reunion until next year, when I hope we will have more time and a better attendance. I had a letter, only yesterday, from Dr. Blake, who had been away, and as I only just returned yesterday from Hot Springs, Ark., it has complicated matters somewhat, so I think the best we can do is to have a rousing reunion in 1912.

Thanking you for your many courtesies and valuable assistance, I remain

Yours very respectfully,

L. H. KELLER.

BRIDGEPORT, CONN., April 11, 1911.

My dear Doctor Brack.—Your letter received and thank you very much for same as I appreciate you would do anything you could for me.

I was appointed as assistant house surgeon beginning August 1, as I don't complete my service here until July 1. Perhaps it might interest you to know that another P. & S. man I met at the examination received an appointment. I think his name is Ryan, class of '08. He comes from Canada. He goes on service on May 1.

Thanking you for past favors, I am,

Yours most sincerely,
Benj. Brooks Finkelstone.

P. S.—Drs. Dobbin and Novak's letters of recommendation did much toward "landing me the place."

ELMIRA, N. Y., May 12, 1911.

Dear Doctor Brack.—I enclose you my check of \$2.00 for Alumni Journal. As I expect to attend the A. M. A. meeting at Los Angeles, I hope I may see you there. Very truly yours,

SHERMAN VOORHEES.

PATERSON, N. J., December 21, 1910.

DR. C. E. BRACK.

 $My\ dear\ Brack.$ —Enclosed please find amount due the Journal. Wishing you and the whole bunch a merry Christmas, I am,

Yours as ever,

FRANK F. McDede.

BALTIMORE, MD., May 29, 1911.

Dear Doctor Brack.—Enclosed you will find my subscription for the Journal, \$1.00, also my promise to subscribe \$20.00 more, in addition to the \$5.00 I have already sent Sister M. Carmelita towards building fund for Mercy Hospital. I will send the \$20.00 as per agreement.

It pleased me very much to read the article of Dr. George J. Howe in the JOURNAL, suggesting a reunion of the class of '92, which, by the way, I am heartily in favor of myself.

Hoping you are well and with my very best wishes, I remain,

Yours truly,

DR. WM. E. MILLER.

Howellsville, N. C., January 11, 1911.

Dr. Brack, Baltimore, Md.

Dear Doctor.—I have, for several months, anticipated the great pleasure of a visit to the P. & S., but it seems quite impossible now, as my entire time is taken. However, will avail myself of the first opportunity of dropping in to see my old friends, so often thought of. Enclosed find check; please don't ever miss sending me a single copy of Journal, it is my only means of hearing from you all.

Give kindest regards to Dr. Ruhräh.

One of your boys,

J. A. POWELL.

CALAHALN, N. C., March 14, 1911.

DR. CHAS. EMIL BRACK.

Dear Doctor Brack.—Enclosed please find one dollar as pay for your Journal for 1911.

I am still trying to practice medicine. I may come out and see you

all when your commencement comes off, if I learn the date, if it should be so I can, and take a little rest and recreation.

Yours fraternally,

J. M. CAIN.

NEW YORK, July 8, 1911.

Dr. Chas. F. Bevan (Dean), College P. & S., Baltimore, Md.

Dear Doctor.—I take great pleasure to inform you that I have received an appointment upon the medical staff of the Mount Sinai Hospital.

Yours very respectfully,

SAMUEL ARONOVITZ, M. D., '11.

DETROIT, MICH., May 10, 1911.

Dear Doctor.—Herewith find \$1.00 for 1911 subscription Alumni Association C. P. & S. Am glad to see each and all numbers of the Alumni Journal.

Yours fraternally, W. L. BABCOCK, '93.

SYKESVILLE, PA., April 21, 1911.

Dear Doctor.—Inclosed please find check for \$3.00 in payment for Alumni Journal for 1909-10-11.

With very kindest regards,

Respectfully yours,

J. FRANK RAINE.

#### Book Reviews.

The Hook-Worm Disease.—Etiology, Pathology, Diagnosis, Prognosis, Prophylaxis and Treatment. By George Dock, A. M., M. D., Professor of the Theory and Practice of Medicine, Medical Department, Tulane University of Louisiana, New Orleans, and Charles C. Bass, Instructor of Clinical Microscopy and Clinical Medicine, Medical Department Tulane University of Louisiana, New Orleans. St. Louis, C. V. Mosby Company, 1910.

This little book is a complete and lucid exposition of the subject of the

hook-worm disease, and one which every physician living in the zone in which the hook-worm is found should own. It is not only accurate and scientific, but is intensely interesting as well.

The book considers the distribution of the hook-worm disease and its economic importance, the zoological features and classifications of hookworms, the relation of ground itch to infection by hook-worms and the various modes of infection, and then follow interesting chapters upon the pathology and symptomatology of the disease. The methods of making the diagnosis are fully described as well as the prognosis and complications. Two of the most important chapters are those on the prophylaxis and treatment, and taking it all in all the book can be most highly recommended.

The book is fully illustrated and is inscribed to Charles Wardell Stiles, Chief of the Division of Zoology in the Hygienic Laboratory, United States Public Health and Marine Service, whose brilliant conceptions and untiring labors have enlarged our knowledge of hook-worm disease, and thereby opened up one of the most important fields of preventive medicine.

Merk's Manual of the Materia Medica (fourth edition). A Ready Reference Pocket Book for the Physician and Surgeon. Containing a comprehensive list of chemicals and drugs—not confined to "Merck's"—with their synonyms, solubilities, physiological effects, therapeutic uses, doses, incompatibles, antidotes, etc.; a table of therapeutic indications, with intersperced paragraphs on bedside diagnosis, and a collection of prescription formulas, beginning under the indication "Abortion" and ending with "Yellow Fever;" a classification of medicaments; and miscellany, comprising poisoning and its treatment; and an extensive dose table; a chapter on urinalysis, and various tables, etc. (Merck & Co., 45 Park Place, New York. 1911. 493 pages. Sent on receipt of forwarding charges of 10 cents, in stamps, to physicians, or to students enrolled in any college of medicine in the United States.)

This is a very valuable little hand-book containing much useful information which may be recommended to both physicians and medical students.

#### AGAIN THE HAY-FEVER PROBLEM.

Undoubtedly the most successful way to treat hay-fever is to send the patient where he will not be exposed to the particular pollen to which he may be susceptible—to prescribe a sea voyage, for instance, or a change of climate. In this manner temporary immunity, at least, is obtainable. Unfortunately, very few patients, comparatively, have at their disposal the necessary time and means for travel. In nineteen cases out of twenty the physician must fight the intractable disease with such weapons as pharmacology and pharmacy have placed in his hands.

Of the remedial agents in the possession of the medical profession the suprarenal substance has proved itself by far the most efficient. While not attaining to the dignity of a specific, it is at least a satisfactory palliative. It successfully antagonizes the symptoms of the disorder and gives the patient a temporary comfort that is not to be despised. It is probably best used in the forms of Adrenalin Chloride Solution, Adrenalin Inhalent, and Anesthone Cream.

The two preparations first named—the former diluted with four to five times its volume of physiological salt solution, the latter with three or four times its volume of olive oil—are sprayed into the nares and pharynx. Any good atomizer that is adapted to oily or aqueous liquids (preferably, however, one that throws a fine spray) may be used. As to the comparative value of the preparations for the purpose named, it may be said that the Solution "takes hold" more promptly, while the astringent effect of the Inhalent is more lasting.

Anesthone Cream is a much newer product, having been introduced to the profession, if we mistake not, in the early months of 1910. Nevertheless it made a great record for itself during the hay-fever season of last year. Few medicinal preparations, indeed, make their debut so auspiciously. The formula came from a prominent practitioner of The Hague, Holland, and combines Adrenalin Chloride and Para-amido-ethyl-benzoate in a bland oil base. Right here some reader may inquire: "What is Para-amido-ethyl-benzoate?" Ask Parke, Davis & Co. They have printed matter which answers this very question. Write for it. Write the company, too, for its literature on hay-fever, addressing your request to the home offices in Detroit, Mich., and mentioning this JOURNAL. You will get some useful and interesting information.

#### PHYTIN

Phosphorus therapy as outlined by some of our European confreres lies along the line first pointed out by Posternak rather than along the lines more generally followed in this country. Posternak isolated the phosphorus principle of plants in 1900 and this was combined with the acid double salt of calcium and magnesium thus making a product that is chemically the phosphorus salt of plant and known as Phytin.

It will be of interest to Journal readers to know that our own Sharp & Dohme have begun the manufacture of soluble compressed tablets of Phytin, the drug itself being imported from the sole manufacturers in Basle, Switzerland. We are requested to extend a cordial invitation to our subscribers to send to S. & D.'s city offices at Howard & Pratt streets for free samples of Phytin Tablets and literature on the therapeutics of the so-called "vegetable phosphorus." Please do us the favor to mention the Journal in your communication.

# Sending the hay-fever patients to the mountains

is all very well—if he has wealth; if he has leisure. There's the rub! Wealth, to most of us, is a dream; leisure, a luxury. The average individual must remain at his post of duty. If he has hay fever he must fight it out there—"if it takes all summer."

## THE BEST MODE OF TREATMENT IS WITH ADRENALIN.

This preparation, in the forms listed below, offers to the medical profession its most efficient palliative in hay fever. Better than any other agent, it controls the nasal discharge, allays the congestion of the mucous membrane, and reduces the swelling of the turbinal tissue. It tends to restore natural breathing, abates the desire to sneeze, and in general induces comfort.

THESE ARE THE PREPARATIONS COMMONLY USED.

#### Solution Adrenalin Chloride

Adrenalin Chloride, 1 part; physiological salt solution (with 0.5% Chloretone), 1000 parts.

Dilute with four to five times its volume of physiological salt solution and spray into the nares and pharynx. (Ounce glass-stoppered bottles.)

#### Adrenalin Inhalant

Adrenalin Chloride, 1 part; an aromatized neutral oil base (with 3% Chloretone), 1000 parts.

Dilute with three to four times its volume of olive oil and administer in the manner described above. (Ounce glass-stoppered bottles.)

Note.—We also supply Adrenalin Ointment and Adrenalin and Chloretone Ointment (collapsible tubes, with elongated nozzles), both successfully used in the treatment of hay fever.

#### Anesthone Cream

(Formula of Dr. J. E. Alberts, The Hague, Holland.)

Adrenalin Chloride, 1:20,000; Para-amido-ethyl-benzoate, 10%; in a bland oleaginous base.

A small quantity (about the size of a pea) is applied three or four times a day, the patient snuffing it well into the nostrils.

Anesthone Cream was used with marked success during the hay-fever season of 1910. The fact that it affords relief which continues for several hours in many cases is worthy of consideration when one remembers the fleeting character of most local anesthetics. (Collapsible tubes with elongated nozzles.)

NOTE.—We also supply Anesthone Tape (likewise useful in hay fever), a selvage-edge tape, one-half inch wide, impregnated with a 1:20,000 solution of Adrenalin Chloride, and 5% soluble salt of Para-amido-ethyl-benzoate, agreeably perfumed. A piece two or three inches long is cut off and inserted in each nostril. (Small vials.)

#### **OUR GLASEPTIC NEBULIZER**

is an admirable instrument for spraying the Adrenalin solutions. It produces a fine spray and is suited to oils of all densities, as well as aqueous, spirituous and etherial liquids. The working parts are one piece of glass. Complete, with throat-piece, \$1.25.

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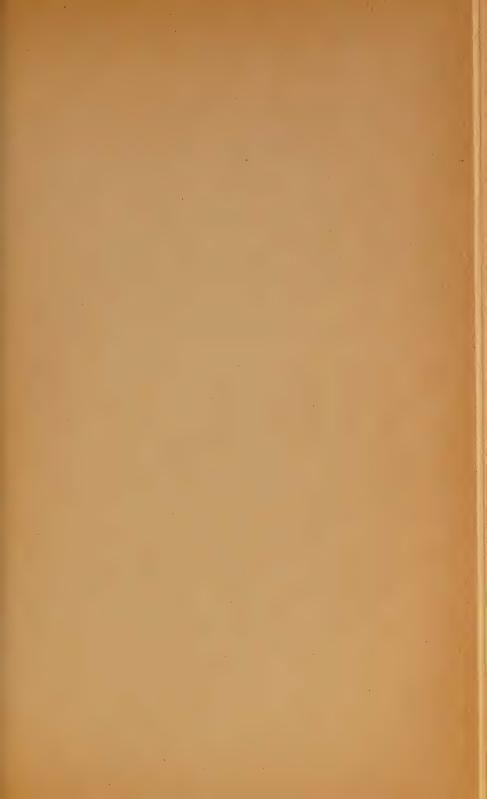


## A QUIET, SECLUDED COUNTRY HOME FOR THE CHRONIC INSANE AND MENTALLY DEFICIENT

Dr. P. H. Stultz ('95) offers unusual facilities in supplying a real home for a limited number of chronic insane or mentally deficient patients.

Dr. Stultz has had considerable experience in institution work and appreciates the advantages of an asylum and home rather than a hospital for a certain class of these unfortunates.

For special information address, Dr. P. H. STULTZ, Supply, Okla.



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C. HAMPSON JONES, M. B., C. M. (Edinburgh), M. D.,

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Professor of Hygiene and Public Health.

JULIUS FRIEDENWALD, A. M., M. D.,

Professor of Gastro-Enterology.

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## THE JOURNAL

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BALTIMORE.

CARCINOMA OF THE UTERUS. By Dr. WILLIAM S. GARDNER, '85.

Histology.—The mucous membrane of the vaginal portion of the cervix is covered with stratified squamous epithelium. The mucous membrane of the cervical canal and the glands in it are lined by a single layer of high columnar epithelium. The surface and the glands of the endometrium of the body are lined with a single layer of low columnar epithelium. From these three varieties of epithelium there are developed three varieties of carcinoma. The most common form of carcinoma of the uterus is developed from the squamous epithelium of the cervix and usually begins at the point of junction of the squamous and columnar epithelium. It is called squamous cell carcinoma or epithelioma. From the high columnar epithelium of the cervical canal is developed the adeno-carcinoma of the cervix. From the low columnar epithelium of the endometrium is developed the adeno-carcinoma of the body of the uterus.

Pathology.—Squamous cell carcinoma of the cervix: The gross appearance of these growths varies widely, but they can be described under three general groups. In an early stage the cervix presents small hard nodules with an unbroken surface, but which bleeds rather easily if manipulated. In other cases a cauliflower-like growth is found projecting from the vaginal portion of the cervix. These projections are very fragile and when broken off bleed profusely. They may be considered the second stage in the development of carcinoma of the cervix, but in many cases this formation never takes place. The third group are those observed after a certain amount of breaking down or ulceration has taken

place. This ulceration may follow directly after the hard nodular stage or it may follow the breaking down of the cauliflower growth. There is present a deep excavation surrounded by hard indurated nodular borders. It bleeds easily on manipulation. If a section of an early carcinoma of the cervix is examined with a microscope the normal epithelium on the outside of the cervix can be traced directly to the point where it begins to dip down into the tissues and the cells change their character. It will be noted that the cancer cells stain very much more deeply than the normal vaginal epithelial cells, that they are irregular in size, and that in the connective tissue just beneath the cancerous growth there is a marked small round cell infiltration. The cancer cells form columns that grow directly down into the sub-epithelial tissues. These columns when cut transversely show what are called the cell nests. They are more or less rounded masses of epithelial cells surrounded by the stroma of the cervix which is infiltrated with small, round cells. When one of the cauliflower projections is examined it is found to consist of a stem of newly formed connective tissue covered on the outside by many layers of irregular epithelial cells. In other words the cauliflower projections are made up of an overgrowth of epithelial cells combined with an owergrowth of the subjacent stroma cells. The stroma is deeply infiltrated with polyneuclear leucocytes and small, round cells.

When a section from the border, or more recently developed portion of an epithelioma that has undergone ulceration is examined the same cell changes are found that are seen in a beginning carcinoma. In the older portions of the growth there is much infiltration of polyneuclear leucocytes into the cell nests. This process of infiltration goes on until there is liquefaction and breaking down of the epithelial masses leaving only the remnants of connective tissue between them. This connective tissue ultimately necroses leaving a deep cavity. The cancerous process starting near the external os rarely extends upward into the uterus farther than the internal os. It has a tendency to metastasize early into the broad ligaments, and later by way of the lymphatics.

Three distinct varieties of squamous cell carcinoma of the cervix are recognized. The first is made up of cells from all the layers of the epithelium. It can usually be recognized by the irregularity in the size of the cells and by the irregular distribution of the chromatin. This type

of epithelioma is the one usually found in the younger women and extends very rapidly. The second variety apparently grows only from the basal layer of epithelium and is known as basal cell carcinoma. The cell nests have very definitely rounded outlines. It can be recognized by the uniformity of its cells both in size and in distribution of chromatin and the usual absence of pearls and prickle cells. It metastasizes less rapidly and the probability of its recurrence after removal is less than that of the first variety. In the third or scirrhus form of epithelioma there is apparently a very slow invasion by the epithelial cells. The cells stain poorly. There is an increase in the connective tissue which apparently affords great resistance to the invading epithelial cells. The result is that the malignant growth makes very slow progress and may extend over a long period of years before there is any great destruction of the tissue.

Adeno-carcinoma of the cervix often begins well up in the cervical canal and frequently progresses until the cervix is almost entirely destroyed before it breaks through into the vagina. When the disease begins in the canal near the external os the lips are thickened and infiltrated. In some cases there is almost a complete destruction of the cervix, only a hard nodular mass remaining which has a central opening in it allowing the outflow of a foul discharge. The growth sometimes entirely closes the cervical canal and the uterus becomes distended with pus. It tends to break through the rectal and bladder walls causing fistulæ. On microscopic examination a very great increase in the number of atypical glands is seen. These glands project out into the stroma of the cervix. The epithelium lining the glands proliferates rapidly having a tendency to pile upon itself and ultimately to fill up the gland spaces. In the later stages of the process it breaks through the basement membrane. The epithelial cells of the adeno-carcinoma differ greatly from those of the normal cervical epithelium. The neuclei may be of almost any shape or form and stain very irregularly. The newly formed cells usually stain deeply. The stroma of the growth is the undestroyed portion of the cervical tissue and is usually infiltrated by small, round cells. Adeno-carcinoma of the cervix has less tendency to break down than squamous cell carcinoma has. It causes very little hemorrhage and consequently attention is rarely called to it until it is far advanced.

Adeno-carcinoma of the body of the uterus usually begins at one point in the endometrium. In exceptional cases the whole endometrium is apparently involved from the beginning. The body of the uterus may be somewhat enlarged. The growth starts usually by producing finger-like projections on the endometrium. On miscroscopic examination it is observed that the number of glands is very much increased; the epithelium lining the glands is modified in character, and the number of epithelial cells tremendously increased. This increase in the number of epithelial cells causes them to pile up within the gland. The proliferation of the epithelial cells is always irregular so that there are scarcely two glands that present the same general appearance. In the later stages the proliferation of the cells may increase to such an extent that the appearance of the gland structures is almost completely lost. The two conditions most frequently confused with adeno-carcinoma of the body of the uterus are a benign adenoma growing from the endometrium and the changes in the glands that are found in early pregnancy. In an early pregnancy there is an increase in the number of epithelial cells within the gland, but there is a decrease in the amount of chromatin in these cells. There is a marked uniformity in the general appearance of all the glands shown. There is no increase in the number of glands. There are present the decidual cells in the stroma.

Causes.—No definite cause of carcinoma is known. It occurs most commonly after the age of thirty-five, although no age is absolutely exempt. The majority of cases are seen between the ages of forty and fifty-five. Lacerations of the cervix apparently favor the development of carcinoma. It has been observed that nearly all women who have epithelioma of the cervix have borne children or have had the cervix forcibly dilated. Adeno-carcinoma of the body of the uterus has been noted with greater frequency in connection with submucous fibroids than under any other condition. The presumption is that the pressure exerted by the fibroid upon the mucous membrane has a direct relation to the development of the carcinoma. It is very probable that carcinoma is due to a specific infection and that laceration of the cervix and pressure from fibroids serve only to increase the opportunities for infection.

Course.—In all forms carcinoma of the uterus is in the beginning a local disease which if removed completely will not return. The squamous

cell carcinoma metastasizes first to the broad ligaments and later through the lymphatics and by direct continuity of tissue to all other organs in the pelvis. The patient loses strength rapidly from the continuous loss of blood and from toxemia. Toxemia is due to the absorption of ptomaines formed in the process of suppuration and necrosis. That form of epithelioma developed from all the layers of the squamous epithelium destroys tissue the most rapidly and metastasizes the earliest. prognosis in this form of epithelioma, however early it is seen is always bad. The basal cell epithelioma develops more slowly and the scirrhus is the least malignant of the epitheliomata. Adeno-carcinoma of the cervix produces so little disturbance that it is usually not discovered until the cervix is practically destroyed and metastasis to the broad ligaments has already taken place. It is considered the most malignant of all the carcinomata of the uterus. Adeno-carcinoma of the body of the uterus does not metastasize early, but does promptly cause hemorrhage. Consequently where the proper examination is made it can often be removed before it has progressed very far. A much larger percentage of patients suffering from adeno-carcinoma of the body are permanently cured than those who have any other form of carcinoma of the uterus. If neglected it ultimately extends through the uterine wall and continues to develop in any of the pelvic viscera with which it comes in contact. No statistics giving the permanent recoveries after operation for carcinomata of the uterus are of any value unless the definite varieties removed are stated.

Symptoms.—The most important symptom of carcinoma of the uterus is hemorrhage. In women during the menstrual age this hemorrhage usually shows itself at first as an increased menstrual flow which gradually increases until it becomes more or less continuous. Occasionally very profuse hemorrhages occur. Hemorrhage after the menopause is especially significant of carcinoma. This is the period of life in which carcinoma comes most frequently. Carcinoma is one of the few things that produces hemorrhage after the menopause. All cases that bleed excessively about the time of the menopause and all cases that bleed even slightly after the establishment of the menopause should be immediately investigated. The squamous cell carcinoma does not cause hemorrhage until after it begins to break down. The adeno-carcinoma of the cervix

may never cause any hemorrhage. Adeno-carcinoma of the body of the uterus occurring before the establishment of the menopause causes at once an increased menstrual flow. Where the growth begins after the establishment of the menopause the hemorrhage is usually in the beginning a slight continuous dribble which has a tendency to increase in volume.

Even before hemorrhage occurs there is frequently a thin watery discharge. Unfortunately leucorrhoea is such a common condition that very little attention is usually paid to the discharge due to a malignant growth. As the disease progresses this watery discharge becomes discolored with blood. During the process of necrosis there is a profuse extremely fetid discharge. It has a tendency to irritate the mucous membranes over which it passes. The odor is so characteristic that it is a very material aid to diagnosis.

Pain due to carcinoma does not begin until after the structures outside the uterus are involved. There is nothing characteristic about it and it varies according to the organs involved in the metastasis. It usually comes on too late to be of any practical use in making a diagnosis.

The cachexia caused by carcinoma does not appear until the disease is well advanced and is due to the absorption of toxins and to the loss of blood.

Diagnosis.—It is of the greatest importance to make a diagnosis of carcinoma as early as possible. The diagnosis of epithelioma of the cervix can usually be made by ordinary vaginal examination. The cervix may be found to present irregular nodules or a cauliflower growth or a crater-like ulcer with hard elevated edges. Some hemorrhage is almost invariably produced by the examination. The condition of the cervix taken in connection with the age of the patient and the history of hemorrhages are very significant of carcinoma. A portion of the growth for microscopical examination can be obtained either by curetment or by clipping a wedge-shaped portion from the border of the growth. The microscopical findings are described in the paragraph on pathology.

Adeno-carcinoma of the cervix as a rule causes no enlargement of the cervix and no hemorrhage or other discharge until it has extended very widely and begins to break down. An early diagnosis of adeno-carcinoma of the cervix is usually only made in the course of routine microscopical examination of uterine scrapings. In adeno-carcinoma of the

body of the uterus attention is usually directed to the condition by the hemorrhage. On bimanual examination it can usually be recognized that the body is slightly enlarged. The diagnosis must be made from a specimen secured by curetment. The microscopical findings are described in the paragraph on pathology.

Treatment.—There is no occasion to take up a great deal of space at this time in giving the details of treatment. The ideal treatment for carcinoma of the uterus is the extirpation of all tissues involved in the growth. Unfortunately in many instances the carcinoma has extended into tissues so far beyond the uterus before it is discovered that it is impossible to remove the whole of it. In such cases it is folly to attempt a radical operation and the attending physician should restrict the treatment to palliative measures for the relief of symptoms as they arise. In a general way it can be stated that palliative treatment should be used in these cases in which by ordinary methods of examination it can be recognized that the carcinoma has extended beyond the uterus and especially those in which the broad ligaments are involved to such an extent that the uterus is fixed in a definite position; and that in all cases where the uterus is movable and there is no marked infiltration of the tissues outside the uterus, extirpation of the growth should be undertaken. Under palliative treatment are included the use of the curette and cautery for the control of hemorrhage; vaginal douches to deodorize the fetid discharges and opium to control pain. The operative treatment includes high amputation of the cervix, vaginal hysterectomy, and abdominal hysterectomy. Since squamous cells carcinoma of the cervix very rarely, even in the advanced cases extends up into the uterine tissues beyond the internal os, a high amputation of the cervix with the resection of the lower half of the broad ligaments will come as near removing all the diseased structures as any operation. The high amputation by means of the electric cautery as recommended by Dr. Byrne has given the most satisfactory results. When a complete hysterectomy is indicated the question always comes up as to whether the vaginal or the abdominal route should be used. Advocates of abdominal hysterectomy claim that a wider area of the broad ligament and the lymphatic glands can be removed through the abdominal wound than through the vagina. It has been demonstrated that metastasis ordinarily takes place by direct continuity of tissue into the broad ligament and that in only about thirteen per cent of all cases is metastasis confined to the removable pelvic glands. It is impossible to tell by macroscopical examination which of the lymphatic glands are involved. Many glands that are seeen to be enlarged are not cancerous, but the enlargement is due to a bacterial infection. Many glands not materially enlarged may be proved by microscopical examination to be cancerous. If the lymphatic glands are involved, even by the most radical operation it is in most instances impossible to remove all that are involved. Just as wide a dissection can be made of the broad ligaments by the vaginal as by the abdominal route. The immediate mortality from vaginal hysterectomy is very much less than that from abdominal hysterectomy. The high operative mortality of the latter operation more than counterbalances the permanent recoveries secured by the removal of pelvic glands. For these reasons it is believed that there is no advantage in the abdominal over the vaginal hysterectomy, except when there are adhesions due to infection or when there are pelvic growths either uterine or ovarian that cannot be dealt with through the vagina.

#### ROBERT WHYTT, M.D., PROFESSOR OF MEDICINE, UNIVERSITY OF EDINBURGH, 1747-1766.

#### By JOHN RUHRÄH, M. D.

Robert Whytt is one of the men who, famous in their own day and justly so, are disappearing from the encyclopedias of biography. W. Seller, in 1862, from whose address most of the facts in this paper are taken, said that even at that time Whytt's name had been omitted in some of the collections, and the fact that his name does not appear in Hirsch's "Lexicon" is sufficient justification for this short sketch which has been written at the suggestion of Dr. William Osler.

Whytt was born in Edinburgh, September 6, 1714, and was the son of Robert Whytt, of Bennochy, a member of the Scottish bar. He was a posthumous child, born six months after the death of his father. His genealogy may be found in Burke's "Landed Gentry," under the name

<sup>&</sup>lt;sup>1</sup> Read before the Johns Hopkins Hospital Historical Club.

<sup>&</sup>lt;sup>2</sup> Tr. Royal Soc. Edinb., 1861-62, XXIII, pp. 99-131.

of Whyte-Melville. Whytt's second son, having fallen heir to the entailed estate of General Melville, changed the spelling of the old name and took that of the General in addition. The Whytts of Fife claim to be descendants of "Les Blancs" of France, but Simpson in an ingenious paper entitled "The Catstane," thinks it more likely that, in common with the Whytes, they are descended from the Witts of Friesland, one of whom, Witta, the son of Wicte, the grandfather of Hengist and Horsa, according to Simpson, lies buried near Edinburgh.

Whytt's mother died when he was about seven years of age, and he was sent to St. Andrew's to be educated. He was noted for being very industrious and the degree of Master of Arts was conferred on him when he was sixteen. Two years prior to this he had fallen heir to the family estate at the death of his elder brother.

In 1730 he began the study of medicine in the recently founded School of Medicine of the University of Edinburgh. We may digress here to note that in 1724 Porterfield had been appointed Professor of the Institutes of Medicine, but it is not known whether he delivered any lectures then or not. Two years later the Town Council commissioned four Fellows of the Royal College of Physicians to teach medicine, and in the same year that Whytt began his studies the Senatus Academicus recognized the five professors as a Medical Faculty. Mr. Joseph Gibson about this time was appointed to the chair of Midwifery. The other four, appointed previously, were Rutherford and Innes who lectured on the Practice of Medicine, Sinclair who taught the Theory of Medicine and Plummer who gave instruction in Chemistry and Chemistry Pharmacy. The first Monro had been given courses in anatomy in Edinburgh since 1720.

Whytt studied for three or four years, devoting a great deal of his time to anatomy under Monro. There are no incidents known connected with his life as a student, but an extensive lot of notes taken from the lectures of George Young are preserved in the library of the College of Physicians of Edinburgh. The notes are partly clinical on the cases from Young's practice and partly discussions on the theory of medicine. Young, by the way, wrote a "Treatise on Opium" which was published in 1758.

In 1734 Whytt went to London where he visited the hospitals and became a pupil of Cheselden. From London he went to Paris where he

studied under Winslow and attended the clinics at "La Charité" and the "Hôetel Dieu." From Paris he went to Leyden to hear Boerhaave, who at that time was very old, and his pupil Albinus. In April, 1736, he took his medical degree at the University of Rheims which was much visited at that time for the purpose of taking medical degrees, but which was suppressed during the first French Revolution. Rutherford and Porterfield had also been graduated at Rheims as had sixteen of the forty-eight Fellows of the Royal College admitted before Whytt. In the following year the University of St. Andrews conferred the degree of Doctor of Medicine as well. In the same year, 1737, he was admitted as a licentiate and the following year as a member of the Royal College of Physicians of Edinburgh.

He started into practice and was said to have been very successful from the first. He married Miss Helen Robertson, who is said to have been the sister of General Robertson, the Governor of New York. Two children were born to them, both of which died in infancy. His wife died in 1741 and in 1743 he married a Miss Louisa Balfour. The result of this union was fourteen children, six of whom survived their parents. Mrs. Whytt died about two years before her husband.

In 1747 Whytt was given a commission to the Chair of the Theory of Medicine. It is not known when he began his work in the University, but probably some years before, when, Sinclair's health failing, he was a substitute professor. The minutes of the Town Council relative to his election say that he "had given universal content to all the gentlemen learned in the science." When Inness died Whytt was chosen to fill the vacancy made in the four original professorships.

In 1752 Whytt was elected a fellow in the Royal Society of London, and he subsequently contributed several papers to the transactions.

He was a correspondent of Sir John Pringle, who after Whytt's death

\*Dr. Osler has called my attention to a quotation from the diary of "that gossipy parson-physician," Dr. John Ward, which throws some light why degrees were taken at Rheims and other Universities rather than at Leyden. "Doctor's degree at Leyden costs sixteen pounds besides the feasting of the Faculty; at Angers not above nine pounds, and feasting not necessary neither."

Page 12. Diary of Dr. John Ward, Vicar of Stratford, 1648-1679. MS. in the Library of the Medical Society of London. Arranged by Charles Severn, M. D., London, 1839.

assisted his son in collecting and editing his works. He also corresponded with other physicians. Especial mention may be made of Dr. Alexander Garden, Charleston, South Carolina, whose name is perpetuated in the Genus Gardenia, the garland flower. Whytt gives an account of a new plant which Garden had described and written him about and he also mentions the vermifuge action of the Carolina pink of which he had heard from another Charleston physician, Dr. John Lining. These papers were published in the "Edinburgh Essays, Physical and Literary." He also gives an account of yellow fever at Charleston, which he had received from Dr. Lining.

In 1761 he was made first physician to the King of Scotland, and it is said that the position was created especially for him. In 1763 he was elected President of the Royal College of Physicians of Edinburgh, which office he held until the time of his death.

In 1765 his health began to fail. His first symptoms were diuresis, especially at night, an inequality of the pulse and occasionally depression of spirits. He was confined to his house, driving out only on fine days. As the diuresis lessened he had symptoms of irritation of the intestinal tract and also could not lie on his right side. He had considerable cough and subsequently dyspnea. He was not regarded as seriously ill; he himself, as did his medical attendants, Dr. Rutherford and Dr. John Clerk, thought it to be gout. He was incensed at Porterfield for calling his complaints hypochondriac. He continued to take great interest in what was going on about him. The attacks of weakness and oppression led him to take large quantities of animal food and of spirits, in the summer of 1765 his legs and thighs became covered with purple spots as if he had scurvy, but there were no mouth symptoms. On being put upon a vegetable diet the spots disappeared. Later on he had what was apparently a hemiplegia from which he recovered sufficiently to be wheeled about the house in a chair. One bad symptom after another developed, however, until general anasarca set in. Two days before his death, on noting his own condition, he remarked, "The end has come at last." He died on April 15, 1766.

On making the autopsy it was found that he had in the left pleura "five pounds of fluid mixed with a gelatinous substance, and in the right two pounds of serum. There were adhesions on the left side. The lungs were healthy, but the heart seemed atrophied. There was very little water

in the abdomen and the abdominal viscera were free from disease. There was a red spot, the size of a shilling, on the mucous membrane of the stomach. There were concretions in the pancreas.

His funeral was public; the professors of the University, robed in their gowns and preceded by the mace, escorted the body to the grave, while the entire College of Physicians followed in the procession. He was buried in Greyfriars Churchyard, where there is still a tablet to him and his wife.

As to what sort of teacher Whytt was we are left very much in the dark. He delivered his lectures in Latin, and he is said to have been very proficient in that tongue. Up to 1762 he used as a text-book the "Institutes" of Boerhaave, but after that he adopted the "Pathology" of Gaubius.

Whytt was a rather prolific writer, and his works not only ran through more than one edition but some of them were translated into French, and one or two of them into Norwegian, as will be noted later. A German edition of his works was published after his death.

In 1743 he published in the "Edinburgh Medical Essays" a paper "On the Virtues of Lime-Water in the Cure of Stone." It had happened some years previously that a certain Mrs. Stephens had been granted five thousand pounds by an act of Parliament for her secret cure of stone. It seems that the mixture, as it was administered, was very bulky and objectionable, and attempts were made to eliminate the non-essentials. A Dr. Hartley, of Bath, managed to reduce it to two and a half ounces of soap and seven scruples and a half of powdered egg-shell as an average daily dose. Whytt conceived the idea that lime-water might be of service, and accordingly in 1741 he started to prescribe it, usually with soap. He seems to have had great success and his paper, which was republished separately in 1752 with alterations and revisions, ran through several editions. It was translated both into French and German.

Whytt's treatment was to give an ounce of Alicant Soap and about three pints of lime-water daily. Most of the calculi he came across were evidently uric acid, but at his time there were no distinctions made. He did note, however, that some that he found did not act as did the ordinary ones when placed in lime-water outside the body. His original conclusion was that lime-water was a pretty universal solvent of urinary calculi.

He had a great deal of correspondence with noted personages of the time on the subject of stone, and he includes their cases in his reports.

In 1750 he published in the "Edinburgh Essays, Physical and Literary," an article on the various strengths and properties of lime-water. Whytt, in common with others of his day, did not think that lime-water was a solution of lime but that it was a liquid having peculiar properties which it derived from the lime. He goes into elaborate details about the experiments which were the result of a controversy with Dr. Alston. It was this very paper that led Black to undertake his investigations on the relations between the calcareous earths and fixed air.

In 1751 he published his work "On the Vital and other Involuntary Motions of Animals," which he had been preparing since 1744. This attracted widespread attention throughout Europe. Seller, in his "Address" on Whytt, says that it was owing to a misapprehension of certain expressions used by him that led to the current belief that he was an exponent of the theory of Stahl. Seller also thinks that much of the lack of interest in Whytt is on this account, that the glory of the master overshadowed the pupil. He protests against the idea that Whytt was a follower of Stahl and goes into his explanations at considerable length, from which I borrow extensively.

Stahl's idea was that "there is a rational, provident, conscious principle that originates and directs all the phenomena of living Nature." From the earliest times this idea has prevailed. The ancients supposed the presence of Dryads and Nymphs and the like to explain the actions of the world organic and inorganic. Hence arose the idea of a world soul, of an animal soul and of a vegetable soul of the older philosophers. This idea of a soul producing the phenomena of animal life is present in the writings of Paracelsus and indeed of all the middle age writers. It was the idea of Descartes and was the essential of the philosophy of Van Helmont and of Stahl.

Seller explains Whytt's position as follows: "In common it is true not only with physiologists of the Stahlian school but with those of all the preceding schools of physiology from Hippocrates downward, Whytt traced animal movements to an anima or psyche; but he differs with Stahl, to borrow the description of Haller, so widely, that he regarded

such movements as being the immediate result of a stimulus, without any reason, intention, or consciousness on the part of the anima.

Whytt thought that the voluntary motions were produced by the immediate action and energy of the mind, and that all the voluntary motions of animals were produced in this way. He thinks that Stahl brought ridicule on his theories by extending this idea of soul influence too far. I may quote here a part of Whytt's writing which gives not only a good idea of what he thought of his style as well.

"But there is no need of understanding the nature of the soul, or the way in which it acts upon the body, in order to know that the vital motions are owing to it; it is sufficient if we know from experience that it feels, is endued with sensation and has the power of moving the body." "It is no sufficient objection that we are unconscious of the mind in the vital and other involuntary movements; for some of the voluntary motions are performed while we are insensible of the power of the will being exerted in their direction."

"Some, indeed, have gone so far as to deny that even voluntary motions are owing to the mind as their proper cause, and have thought the direction of the voluntary muscles, in order to perform the various motions of the body, to be an office which its faculties are not equal to. But if these motions be not owing to the mind, from what cause, external or internal, do they proceed? They cannot be owing to the body alone; and it is vain to attribute them to any law which it may be pretended that the Deity established, since a law can produce no effect of itself; and without some agent to execute, it is only a mere name or empty sound; they must therefore be ascribed to the immediate agency of the Supreme Being, or to that of some general inferior Nature which He has constituted for this purpose, or to the energy of a particular active principle united with the body. The first two propositions are possible, but not probable, as is the last; whence it may be inferred, that not only the voluntary motions, of which we are immediately conscious, but those also which we do not advert to, proceed from that sentiment and intelligent principle with which the Creator has animated our bodies, whose powers and operations, it must be owned, are in many instances as much above our knowledge, as is the nature of its union with the body, or the manner of their reciprocal action upon each other."

Many of Whytt's ideas as expressed in this work are strikingly near what is taught today. His idea of the vital functions of the body was that they were carried on by being dependent on an influence derived from the nervous system. As regards the correlation and harmony of the working of the bodily functions his ideas were evidently correct. His idea as regards the involuntary motions that are not vital are the foundation of our knowledge of the subject today, and he furnished the largest generalization which has been formulated as regards the general activity in the organic world. In Whytt's day these motions were not called reflex but he has given us most admirable accounts of the various types of reflexes without naming them as such, and his ideas were the starting points for later physiologists.

Another point that Whytt brought out but which he could not at that time demonstrate was that the nerve fiber runs intact from one end to the other and the identity of the separate nerve fibrils.

Whytt may be regarded as the great exponent of reflex action. Most authors previous to him had hinted at it or described it more or less vaguely, but he came very near the modern idea of the spinal reflex.

In 1764 Whytt published a book entitled "On Nervous, Hypochondriac, or Hysteric Diseases, to which are prefixed some remarks on the Sympathy of the Nerves." Much of the book is an elaboration of his previous "Essay on Animal Motions." This book is a mass of observations and comments on what we should nowadays call reflex action of various kinds.

The monograph "On the Dropsy in the Brain" was published two years after his death. A short note of introduction will be found preceding this classic, which will be reprinted at a later date.

His collected works were published in 1768 by his son and Sir John Pringle. Among the detatched papers Seller mentions the following as of especial interest:

- "On the difference between Respiration and the Motion of the Heart in Sleeping and Waking Persons."
  - "On the Cure of a Fractured Tendo Achilles."
  - "On the Use of Bark in a Dysentery, and a Hoarseness after Measles."
  - "Observations on the Anomalous and the True Gout."
- "Of an Epidemic Distemper at Edinburgh and Southern Parts of Scotland in 1758."

"On the Use of Sublimate in the Cure of Phagedenic Ulcers."

"Account of an Earthquake felt at Glasgow; also of a shower of Dust falling on a Ship between Shetland and Iceland."

"On the Remarkable Effects of Blisters in lessening the Quickness of the Pulse in Cough, attended with Infarction of the Lungs and Fever."

In closing I shall quote the following characterization of the man by Seller:

"In short, Whytt, though of an ardent temper, really was a man of well balanced feelings, earnest after truth, not unsolicitous of fame, while all the sentiments he expresses indicate a benevolent turn of mind, full of love to mankind, and a determination, at any cost to himself, to fulfill the duties of his station."

#### GIANT-CELL EPULIS OF LOWER JAW.1

REPORT OF A CASE.

#### BY ALEXIUS McGLANNAN, M. D., '95, BALTIMORE.

GENERAL DESCRIPTION.

Epulis is a slightly malignant tumor of the jaw, growing from the connective-tissue cells between the mucous membrane and the periosteum of the alveolar border.

The tumors grow slowly, seldom reach a large size, or cause destruction of the bone. The teeth are often loosened by the growth of the tumor into the root sockets. As far as is known, these tumors never give metastases, but will recur locally if their removal is not complete. Histologically they are sarcomata of low malignancy, giant-celled and fibrospindle-celled, or vascular fibromata (angiofibroma). An epulis always may be cured by complete excision.

These tumors seem closely related to inflammatory reaction. About 25 per cent of cases give a distinct history of traumatism as an etiologic factor. A certain number of patients date the growth of the tumor from the extraction of a tooth; but here it is more than likely that the tumor led to the removal of the tooth. In many cases the tumor occurs around normal, firm and evenly placed teeth.

<sup>&</sup>lt;sup>1</sup>From The Journal of the American Medical Association, July 31, 1909, Vol. LIII, pp. 379-381.

In the clinical history the symptom of onset most frequently is at the tumor itself. The tongue feels the small swelling on the side of the alveolar border of the jaw. Occasionally pain may be the first symptom—toothache or pain in the jaw itself.

The small tumor looks like a gum-boil, but is not so painful or tender; often, indeed, it is not at all sensitive. The swelling begins on the inside of the jaw at the border of the teeth and extends down on the alveolar process. As it grows it surrounds the tooth or teeth and extends on the outer border. The growth is always greatest on the inner side of the teeth, and is never confined to the outer side alone.

The tumor is always firmly attached to the teeth, or to the alveolar border. It shows little tendency to infiltration beyond the alveolar process. On the lower jaw it is distinctly limited by the alveolar border, while on the upper jaw it may infiltrate below the mucous membrane over the hard palate. A vascular epulis may pulsate.

The mucous membrane over the tumor remains intact for a long time. When it ulcerates the surface of the tumor appears red, finely lobulated and vascular. From such ulcers there are frequent slight hemorrhages.

The epulides occur at all ages, being most common in the third decade of life. They usually have a history of long duration, and are more common in women than in men. The position of the growth is most often about the bicuspids and first molars; it is less frequently found around the incisors, and is extremely rare posterior to the last molar teeth.

Differential diagnosis must be made between epulis and (1) sarcoma of the bones of the jaw, (2) the dentigerous cysts, and (3) adamantine epithelioma.

The alveolar limit of the epulis distinguishes it from the periosteal sarcoma. While these tumors may appear at the alveolar border, the swelling spreads rapidly over the body of the bone. More often the periosteal tumor begins on the body and extends to the border.

The dentigerous cyst is formed by the distention of the connectivetissue sac about an undeveloped tooth. The distending cyst thins the overlying bone by pressure. The growth shows itself as an asymmetrical swelling of either jaw, situated beyond the alveolar process, covered by intact mucous membrane and a thin shell of bone.

The admantine epithelioma may be considered a dentigerous cyst whose

cavity is filled with proliferated enamel epithelium. It has the same clinical symptoms as the syst. Both tumors are shown in X-ray pictures as areas of bone absorption, and at exploratory incision are easily recognized by the character of their contents.

Treatment of epulis is by conservative operation. When the tumor is large and spreads over the area of several teeth, an incision is made through healthy mucous membrane, the teeth are extracted, and the tumor with a portion of the alveolar border is removed. An operation of this extent will always cure the disease.

In early cases, and when the tumor takes in only one tooth root, it is sufficient to take the tooth and tumor, dividing the mucous membrane and burning the tooth socket with the Paquelin cautery. Still earlier tumors may be removed by the cautery alone without extracting the tooth. This very conservative treatment of the small tumors is justified, because by this means we are able to avoid deformity and run no risk beyond that of local recurrence, in that these tumors do not form metastases, even after repeated recurrences. When the tumor is a recurrent one, however, it is better to do the radical operation outlined above.

The following case is of interest because of the rare position of the tumor, posterior to all the teeth, in consequence of which a rather extensive operation was required for its exposure and removal:

#### REPORT OF CASE.

Patient (Surg. No. 555).—A white man, aged 50, was admitted to Dr. Bloodgood's wards at St. Agnes Hospital, July 22, 1908, for the cure of a tumor (epulis or giant-cell sarcoma) of the lower jaw. His previous history was unimportant, except for the repeated attacks of quinsy. There was nothing in the history or physical examination to suggest lues. The swelling of the jaw had been present three years, beginning as a small lump on the inside of the angle of the jaw, on the right side. This gave him no pain, and the growth had extended slowly without tenderness or pain. For about a year the last molar tooth on this side had been loose, and during this time the patient had toothache, which he relieved by picking the tumor so that it bled. The growth would bleed occasionally, especially after anything hard was masticated. The patient felt that the original lump began as a result from a carious wisdom tooth whose roots had never been extracted.

Examination.—The fungous swelling extended from the angle of the jaw to the anterior pillar of the fauces, and forward to the second molar tooth. This tooth was loose and tilted inward. The surface of the growth had the appearance of fibrous granulation tissue. It felt soft, but was not friable and did not bleed when handled. The tumor was distinctly limited to the alveolar

process, and did not extend on the cheek or tongue. The submaxillary lymphatic glands were palpable.

The patient was given an antiseptic mouth-wash and a chlorate of potash tooth-paste, and put on sterile food for six days preparatory to operation.

Operation, July 28, 1908 (McGlannan).—The ether was administered by Dr. S. G. Davis, by means of his spray and tube. The cheek was split from the angle of the lips to the ramus of the jaw, below the line of the parotid duct. This gave excellent exposure and no trouble was experienced in dividing the healthy mucous membrane and periosteum beyond the tumor. By blunt dissection the periosteum was lifted and a thin shell of bone taken with the tumor. In order to do this the first molar was extracted and a hole drilled just under it. The Gigli saw was passed through this hole and the bone cut through by means of it. The removal of bone was completed with bone forceps and the raw surface burned with the Paquelin cautery. Closing the wound, the mucous membrane of the floor of the mouth and of the outside of the jaw were drawn toward one another with fine silk. The cheek was sutured with fine silk inside for the mucous membrane, and alternate fine and course silk on the outside for the skin and muscles. The lip was carefully restored with fine silk sutures. A protective drain was put in the posterior angle of the cheek wound and the anterior portion sealed with foil, cotton and collodion. The face was then put up in a voluminous gauze dressing with a crinoline helmet.

Postoperative History.—The patient made a good recovery. There was a little discharge of pus from the posterior portion of the wound for some days, and a salivary fistula remained for about two weeks. The lip end of the wound healed firmly by first intention. There was no deformity of the mouth, and the scar was entirely concealed by the patient's beard. There has been no sign of recurrence of the tumor.

Pathologic Report (Path. No. 9124).—Gross description: The fungous tumor is elliptical, 2.5 cm. and 2 cm. in diameter, and elevated about 1.5 cm. It was removed with mucous membrane, periosteum and bone. The tissue was firm and almost entirely covered by mucous membrane. On section the surface was dark red, lighter at the base with perpendicular striations. Nothing was expressed on pressure. The tumor was distinctly circumscribed and did not infiltrate the normal tissues. No tooth roots or cavities were present.

Microscopic Examination: The section showed giant cells in an extremely vascular stroma with marked tendency to fibrosis and distinct lobulation. There was some blood pigment present. The mucous membrane shown is normal.

114 West Franklin Street.

## A REPORT ON "LOW COUNTRY FEVER," DIAGNOSED AS "DENGUE."

BY FIRST LIEUT. CHARLES H. HALLIDAY, MEDICAL RESERVE CORPS, U. S. A.

The disease here reported has existed in this locality (Beaufort County, S. C.), from time immemorial, and is known by both the profession and laity as "Low Country Fever" and is considered a form of malaria.

It is characterized by sudden onset (preceded in about 50 per cent of the cases by a chill), rapid rise of temperature, increased pulse rate, nausea and vomiting, moist and coated tongue, congestion of visible mucous membranes, headache, lumbar pain, muscular soreness, and pain in bones and joints of varying intensity. An eruption occurs in some cases and in the severe type epistaxis is often a troublesome symptom.

The following histories are from men admitted to Post Hospital and are typical of all cases which have come under my observation. There were 18 cases or 46 per cent admissions for this disease during the months of October and November, 1910:

CASE No 1. G. E. D. Reported on September 1, complaining of "cold in head." Temperature normal. Admitted to hospital at 5 p. m., September 3, temperature 105. Stated that he had a chill between 3 and 4 p. m. Complained of severe headache and pain in lumbar region.

September 4. Temperature at 8 a. m. 100.2, at p. m. 99.3. Free from pain and states that he feels all right.

September 5. Temperature normal and patient feeling well. Temperature remained normal until September 11, when he was returned to duty. During this period no symptoms whatever.

September 12. Readmitted to hospital at 5 p. m., stating that he had chilly sensations during the afternoon. Temperature at time of admission, 105.2.

September 13. Temperature remains up. Vomited at 10.50 a. m. and 12.30 p. m. Bowels watery, moving at 11 a. m., 12.40 p m., 5.55 p. m., 6.30 p. m., and 7.10 p. m. Complains of severe frontal headache. Conjunctiva injected; no photophobia. Face flushed. No appetite. Urine decreased in quantity and highly concentrated.

September 14. Temperature remains elevated. Pulse full and rapid. Pains in groins and lumbar region. Headache continues. Bowels moved at 9 a. m. and 3 p. m. Complained of feeling chilly at 3.45 p. m. No desire for food.

September 15. Temperature ranged from 101 in morning to 103.2 in afternoon. Pulse, 92. Still complains of pain in back and left groin; also severe pain in left testicle. Slight headache. Conjunctiva clear. No flushing of face or body.

September 16. Temperature normal at 11 a.m. Complained of cold feet in afternoon and at 6 p. m. stated that he felt chilly. Temperature reached 104.4 at 9 p. m. Pulse ranged from 72 to 90 during the day. Bowels moved twice during the day. Appetite remains poor. Eruption over body.

September 17. Temperature at 7 a. m., 103. Gradual decline during the day and at 9 p. m. had fallen to 99. Pulse, 74. Bowels moved twice. Free from pain. Nothing tastes well.

September 18. Temperature normal at 8 a.m. and remained so throughout the day. Patient states that he feels entirely free from pain, but that food has no taste.

September 19. Temperature normal. Appetite somewhat improved.

September 20-22. Patient still in bed. Temperature normal.

September 23-27. Temperature remains normal. Appetite returned, and patient states that he feels as well as he ever did. Up and walking about the hospital and grounds.

Blood examination negative for malaria and typhoid. (Army Medical School Bacteriological Laboratory, Washington, D. C.)

September 27-30. Temperature has remained normal. Patient feeling all right. Returned to duty September 30.

CASE No. 2, W. D. F. States that he began feeling badly Friday, September 23, but attributed it to having been on guard the night before. Felt drowsy all day Saturday and believed he had some fever. Had chill at 8 a. m., Sunday, September 25; admitted at hospital at 6.10 p. m., temperature 103, face flushed, conjunctiva injected, complained of orbital headache and severe pain in lumbar region. Night very restless.

September 26. Temperature ranged from 100.6 at 8 a. m. to 101.2 at 4 p. m. Pulse, 100. Headache and backache continue. Appetite poor. Tongue moist, red about edges, and heavily coated in center. Had a poor night, sleep being disturbed by pain in head and back.

September 27. Temperature at 7 a. m., 102. Complains of increasing severity of headache and lumbar pain. Muscular soreness throughout body. Abdomen tympanitis. At 8 a. m. had chill, and temperature reached 105.6 by 9.15 a. m. Pain in head and throughout body increased to such severity that patient moaned aloud and rolled from side to side in endeavor to find a comfortable position. Pulse rate 110. Vomited profusely at 8.30 a. m. Passed 11 ozs. of urine at 12.30 p. m., very dark in color, free from albumen. No appetite. Bowels constipated. Two-hour temperature shows a decline of a degree each two hours, when at 9 p. m. it had fallen to 101.2. Toward night patient felt some better, but sleep was disturbed.

September 28. Temperature, 99.6; pulse, 82. Feels much better this a.m. Temperature remained at 99 throughout the day.

September 29. Chill at 8 a. m. Temperature 104.2 at 10 a. m. Complains of severe pain throughout body. Temperature did not fall below 100 during the day.

September 30. Temperature normal during the day, and patient states that he feels very well.

October 1. Chill at 3 a. m. Severe headache and backache. Temperature at 7 a. m., 105. Temperature declined about one degree each two hours during the day. Complains of pain on left side over spleen. Spleen not enlarged.

October 2. No chill this date. Temperature 99 at 7 a. m., reaching 103 by 3 p. m., and then declining during the afternoon and night. Patient resting well.

October 3. Patient feeling well. Appetite gradually returning. Slight pain in left side. Temperature 100 throughout the day.

October 4. Temperature has remained at 99 throughout the day. Slight pain in left side. Appetite improved.

October 5. Temperature 98.6 during the day and night. Spent a restful night, and states that he feels as well as ever.

October 6. Patient up and about. Temperature, 98.6.

October 7. Returned to duty this date.

Case No. 3, L. R. Admitted to hospital at 2 p. m., October 2, having a chill at time of admission, temperature 104.2. Complains of severe frontal headache and pain throughout body by 6 p. m. temperature had reached 105. Pulse, 110. Patient states that he had felt perfectly well until time of chill.

October 3. Had a chill a little after midnight and spent very restless night. Headache continues and severe pain in right lumbar region. Urine normal. Temperature at 8. a. m., 104; gradual decline during the day, when at 8 p. m. temperature registered 101.2.

October 4. Headache and lumbar pain continues. Temperature ranged between 101 and 102.2 during the day. Vomited at 5.45 p. m. Urine highly colored and decreased in amount. No albumen.

October 5. Slight headache this a.m. Temperature at 8 a.m., 101.6. Still complaining of pain in right lumbar region. Headache increased in severity during afternoon. Temperature reached 103.2 at 4 p.m., with gradual decline to 101.4 by 8 p.m.

October 6. Temperature at 8 a. m., 101. Patient states that he is free from all pain. Temperature at 4 p. m., 99.4.

October 7. Temperature 99 at 8 a.m. Patient feeling well. Temperature 98.2 at 4 p. m.

October 8. Patient up and about. Temperature normal. Appetite normal. October 9. Returned to duty this date.

In addition to the above cases there have come under my observation seven cases among the white and fifty among the colored population. The negro population is about 8000, and I believe it would be a conservative estimate to state that at least one thousand cases occurred among these people. I am told by the old natives, that never in their remembrance, has there been so much fever or so severe a type as occurred last fall. The history repeated by them is identical with the histories here reported, and those cases which occurred among the white population, ran a typical course. In no acute disease, have I observed such an extreme degree of prostration from the onset.

### ETIOLOGY OF EPIDEMIC.

As to the specific causative factor of this disease, I have nothing to offer and must content myself with a statement of the facts which seem to favor its propagation.

Climate.—The summer was unusually long, dry and hot, beginning early in April and extending well into November. Very little rain fell during the summer months. Late in September there were heavy rains which filled all ponds and depressions over the island with water.

Mosquitoes.—The mosquitoes were not numerous or troublesome until about October, when they greatly increased in number. The reports on collections of mosquitoes made from this post for the past several years, show that Culex Fatigans is only reported for the fall months, the period when this disease prevails.

Sex.—The cases occurring on the post were all males, while those observed among the civilian population, both sexes were equally affected.

Age.—The youngest case observed was in a child 5 years of age and the oldest, in a man 60 years of age.

That the disease is propagated by the mosquito seems to be borne out by the fact that those cases occurring on the post were limited almost entirely to the men living in the barracks. These are temporary frame buildings, and owing to numerous cracks around doors, windows and in floors, it was impossible to effectually screen them. Each man used his net while sleeping, but this did not protect during the early hours of the evening. Only one case developed among the occupants of the officers' and non-commissioned officers' quarters. This was a line officer, whose duties required him to be out all day and many times at night, he being the only officer present for duty. No cases occurred among the hospital corps. The hospital is a modern brick building, thoroughly screened. That there should have existed such an extensive epidemic among the civilian population is not surprising when it is known that no protection whatever against the mosquito is provided for by the inhabitants of this island.

### BLOOD EXAMINATIONS.

The color index was not disturbed in any case. In all cases several smears and fresh specimens were examined at various stages of the disease for malaria and found negative. Smears from Cases 1 and 2 were also sent to Washington and reported negative from there. An eosinophila was observed in the majority of cases.

#### DIAGNOSIS.

The seasonal period in which this disease prevails, and the absence of catarrhal symptoms should serve to differentiate it from influenza. The absence of yellow fever from the States, the slower pulse, jaundice and

hematemesis in yellow fever, will exclude it. The only disease with which it is likely to be confused is malaria, and the blood examinations should clear this up. Should there be any doubt as to the correctness of the blood examinations made by the writer, the examinations at the Army Medical School Bacteriological Laboratory, of smears from cases Nos. 1 and 2 should remove all doubt as to these cases at least.

### COMPLICATIONS.

No untoward results were observed in the cases admitted to the hospital. Two cases have been reported to me which suffered from a peripheral neuritis of both arms following the disease and one case which was complicated by partial paralysis of the lower extremities, which lasted for ten days.

Convalescence, as a rule, was rapid, but in a few of the civilian cases it was prolonged, they complaining of soreness of muscles several weeks after temperature had declined to normal.

### RELAPSES.

Several of my hospital cases were readmitted and ran a typical course. Whether these were true relapses or reinfections, I am unable to say, though I am inclined to believe they were in the nature of reinfection.

#### TREATMENT.

The following plan of treatment was pursued in all cases: Patients put to bed and given a cathartic, usually 30 cc. Oil Ricini. The diet consisted of milk and broths at two-hour intervals, until the temperature declined to normal.

Pain was the symptom most complained of. In the milder cases, phenacetin, acetanelid and caffeine citrate in combination controlled the pain. In the severer cases, morphia was required. It was given in 8-mgm. doses, hypodermically, and repeated in two hours if required. More than the second injection was never required. For the intense headache an ice cap brought grateful relief. A cold sponge bath was employed to reduce the temperature, and at the same time served to diminish the restlessness.

In some cases, quinine was given at the onset, while in others it was withheld until the disease was well established. From my observations, I am of the opinion that the judicious use of quinine at the onset will serve to shorten the course of the disease, while in those cases which are well established, the drug has no specific action. During convalescence a general tonic was given.

### CONCLUSIONS.

That "Low Country Fever" is Dengue. That this disease existed in Beaufort County, S. C., during the fall of 1910, in epidemic form. That it will continue to exist in sporadic and epidemic form until the inhabitants realize the necessity of providing themselves with protection from the bites of mosquitoes.

### Correspondence.

SUMAS, WASH., Aug. 25, 1911.

DR. CHAS. E. BRACK, Baltimore, Md.

Dear Doctor Brack.—I am enclosing you check for \$1.00 subscription to the JOURNAL for 1911. I am always glad to get it and I note with pride the many improvements being made this year in the college and hospital. I am looking forward with pleasure to a visit back there in the very near future.

With kind regards, I remain,

Yours very sincerely,

M. T. DALTON, '06.

CHERITON, NORTHAMPTON Co., VA., Aug. 7, 1911.

Dr. Chas. Emil Brack, Baltimore, Md.

Dear Doctor.—I enclose one dollar to pay for Journal of alumni of our Alma Mater. You are certainly keeping us in touch with each other as no other medium could. I have been hearing occasionally from some of our class of '79 and I am always glad to know of any honors or other good fortune that comes to the class especially and to the alumni as a whole. I receive an occasional letter from our mutual friend Dr. Geo.

H. P. Cole, secretary of class '79. Has he published the life of the class yet? He wrote me there was some delay in getting material together. I look back with a great deal of pleasure to our class reunion and regret that Howard of Rochester will not meet with us again. Unless I am mistaken I saw a notice of his death. A proposition was made for a five-year reunion of class which I think will be next year. My wife's health has been broken down and I have been very busy for the last few years. Wish I could go to Baltimore and may be able to do so. I will certainly call to see you and visit the old familiar lecture rooms and hospital, Saratoga and Calvert Streets. With best wishes for all, I am,

Sincerely yours,

Julius Thomas Hall, '79.

HAGERSTOWN, MD., Sept. 4, 1911.

DR. CHAS. EMIL BRACK, Baltimore, Md.

My dear Dr. Brack.—The subscription to the Journal is a small matter, but it brings good results, as it has put me in touch with one of my old class mates that I had lost sight of for years, Dr. W. O. P. Lee, Reynoldson, N. C. Put him on our list.

I am still hoping our reunion next year will be a howling success. With best wishes for you in your good work, I am,

Yours very truly,

L. H. Keller, '75.

NESCOPECK, Pa., Aug. 7, 1911.

Dr. Chas. E. Brack, 500 E. 20th St., Baltimore, Md.

My Dear Doctor.—In the July issue of the Journal of the Alumni Association I notice a list of the class of '86 whom you can not locate. Among them is the name of John T. Husler. John was my room-mate. He died a few years after graduating. A splendid fellow, and had he lived would have been a success, and an honor to the profession and our college. The others named I can give no information of. I would love to attend a reunion of our class of '86. My sincere regards to Dr. Friedenwald and any others of the class.

Fraternally yours,

J. J. Myers, '86.

WILLIAM S. GARDNER, M. D., EDITOR, 6 W. Preston Street.

JOHN RUHRÄH, M. D., Associate Editor, 839 N. Eutaw Street.

CHAS. EMIL BRACK, M. D., Business Manager, 500 E. Twentieth St.

# THE JOURNAL

### OF THE ALUMNI ASSOCIATION

OF THE

# COLLEGE OF PHYSICIANS AND SURGEONS, BALTIMORE.

### MERCY HOSPITAL.

By the time this number of the JOURNAL is issued the new addition for Mercy Hospital will have been completed and occupied. Since a description of the addition was published in the last number of the JOURNAL it is not necessary to repeat it here. The increase in the number of beds comes none too soon, for during the past year the capacity of the hospital has been taxed to its utmost. There have been many annoying delays in the admission of patients due to the fact that the demand for space has been greater than the supply. The amount of surgical work both on the private and public sides has increased tremendously in the last few years. This increase has been due not wholly, but largely to the establishment and maintenance of an excellent operating room technique. For several years the position of the sister in charge of the operating room has been regarded as a permanent one. Changes have been made only when it has been unavoidable. Continuity of service, conscientious application to duty, the willingness to adopt improvements and the intelligence to convert ideals into practical results have made the operating room technique of Mercy Hospital second to no hospital in the country.

### Dbituary.

Dr. J. E. Jewell, '81, of Portland, Ore., died suddenly at Mount Talbor, Ore., May 24.

Dr. WILLIAM R. COSGROVE, '80, of Derry, Pa., died in Mercy Hospital, Pittsburg, June 22, from disease of the liver, aged 54.

Dr. Julian E. Wood, '69, for many years acting assistant surgeon U. S. P. H. and M. H. Service and surgeon of the Norfolk & Southern railroad, health officer of Pasquotank County, N. C., died at his home in Elizabeth City, June 1, aged 66.

Dr. Greer M. Nickell, '81, proprietor of the Millboro Sanitarium, Millboro, Va., died at his home in Millboro, June 27, from the effects of a gunshot wound of the head, believed to have been self-inflicted with suicidal intent, while suffering from ill health, aged 60.

### Warriages.

Dr. Waitman Zinn, '11, was married Wednesday, July 26, to Miss Katherine Burgess, of Baltimore.

Dr. Reuben Elmer Schall, '04, was married Wednesday, June 21, to Miss Nettie Mahaffey, of Harrisburg.

Dr. John H. Steenbergen, '08, of Huntington, W. Va., was married September 20, to Miss Jessie Fitch, of Morganstown, W. Va.

Dr. Nathan B. Bordensky, '07, was married Thursday, June 29, to Miss Sadie Nachlas, of Baltimore. The doctor has opened an office at 2114 Wilkens Ave.

Dr. Harrison Lyons Brehmer, '10, was married July 12, at Lancaster, Pa., to Miss Carolyn Mae Snavely. Dr. Brehmer is located at 497 W. Hallam Ave., Washington, Pa.

### Personal Motes.

Dr. Walter Madden, '97, is the mayor of the city of Trenton, New Jersey.

Dr. D. C. Mock, '04, has been appointed assistant superintendent of Mercy Hospital.

Dr. M. M. Reppard, '92, of Middlebourne, W. Va., is the president of Tyler County Board of Health.

Dr. Charles H. Bruckner, '01, has been obliged on account of his health to give up his practice in Newark.

Dr. Clarence E. Flowers, '05, Columbia, N. C., reports that he enjoys reading the Journal and that he is making a success of his practice.

Dr. W. A. Long, '82, of Frederick, Md., reports that Dr. John D. S. Young, '86, is located in Taneytown, Md., and is ministering to the soul instead of the body.

Dr. William H. Thearle was with the army at San Antonio, Texas, and was in active service on the Mexican border. He has been ordered to Fort Leavenworth, Kansas.

Dr. Grafton E. Day, '94, of Collingswood, N. J., was awarded the first prize of \$100 for the best essay on Infantile Paralysis at the annual meeting of the State Medical Society of New Jersey.

### Correspondence.

Mt. Arlington, N. J., Aug. 12, 1911.

My dear Dr. Brack.—Enclosed you will find one dollar in payment for the 1911 ALUMNI JOURNAL.

I read with much interest each article. As well as being instructive it helps to take me back once more to my college days, which is to me a pleasant thought.

With best wishes for the school and all connected therewith, I remain,
Yours fraternally,

CHAS. D. GORDON, '09.

Dana, W. Va., Aug. 7, 1911.

Dear Doctor Brack.—Find enclosed the sum of one dollar (\$1.00), subscription to the JOURNAL for 1911. If I am in arrears any please notify me of same and I will settle at once.

I am located at Coal Fork, W. Va., and doing list practice. Have been receiving the JOURNAL regularly and am very much pleased with it.

With much success to you in your work and kindest personal regards to all the faculty,

I am very truly and fraternally yours,

G. F. Grisinger, '10.

ELDERSBURG, MD., Aug. 19, 1911.

DR. CHAS. E. BRACK, Baltimore, Md.

Dear Doctor.—I inclose check for bill received yesterday. I shall be glad to do anything to help along the reunion of class of '92. I would suggest the members in Baltimore and vicinity get together before long and map out a definite plan and then push it along. You can count on me.

Very truly yours,

M. D. Norris, '92.

FINDLAY, OHIO, Aug. 5, 1911.

CHAS. E. BRACK, M. D., Baltimore, Md.

Dear Doctor.—Find enclosed subscription to the Journal, which I am very fond of reading. A few days ago I received notice of my appointment as medical director of the Modern Woodmen of America for another term of three years. Kindest regards and best wishes.

Fraternally yours,

Don C. Hughes, '93.

LEXINGTON, N. C., Aug. 5, 1911.

My dear Doctor Brack.—Please find enclosed check for \$2.00 for Alumni Association dues, and continue sending the Journal to me. My brother and partner, Dr. Joel Hill, died last November. I think his death was reported by some friend and was announced in the Journal.

I want to report the happy marriage of my friend and fellow townsman, Dr. Charles Meade Clodfelter, of the class of '05. He was married to Miss Lucile Hoge on the 1st day of February, 1911, and is now living a beautiful and happy life. The doctor enjoys the esteem and confidence of all and is doing a large and lucrative practice. Please give notice of the doctor's marriage in the next issue of the Journal. From the above brief facts you can write him up a nice notice, and it will be much appreciated. I am very sorry I neglected to report this marriage sooner. Clodfelter is a most staunch alumnus. The writer desires a reunion of that greatest class of all of the C. of P. & S., '93. This reunion should be held not later than 1913, anyhow.

Very truly,
DAVID J. HILL, '93.

ALEXANDRIA, LA., Aug. 22, 1911.

DR. CHAS. E. BRACK, Baltimore, Md.

My dear Doctor Brack.—I herewith hand you \$3 to apply on my subscription to our JOURNAL. I have no idea how much I am due on this subscription, but am sure this will not over pay it.

So far as the P. & S. boys are concerned I am here alone; I don't know of but one or two others in Louisiana. When I say I am holding my own professionally and otherwise I guess I am not boasting too much. How about a reunion of the class of '92? Do you think we can have one next spring? I am very anxious to visit my old friends in Baltimore and attend a reunion of my class.

With best regards, I am,

Fraternally yours, J. A. White, '92.

FALL RIVER, MASS., July 20, 1911.

DR. CHAS. EMIL BRACK, Baltimore, Md.

Dear Doctor Brack.—Enclosed find check for two dollars for two years' subscription to the Alumni Journal.

I have just returned from a years' trip abroad, most of which time I spent in Vienna. As you know I have taken up the study of ear, nose and throat diseases, and will limit my practice to these conditions. Have decided to locate in Fall River, and have just purchased a new home in the center of the city. My address in the future will be 228 N. Main St. I want to thank you for sending the Alumni Journal to Vienna, where I received it regularly and enjoyed reading it very much.

My wife also took a ten month's course in diseases of stomach and intestines in Van Noorden's clinic, and she also will specialize in this line. She wishes to be remembered to you and Mrs. Brack, and she joins me in thanking you and Mrs. Brack for the many kindnesses you showed us when we were in Baltimore. Please kindly remember us to Drs. Beck, Gardner, Ruhräh and Gillis.

The opportunity to study clinical material in Vienna is very fine, as it is concentrated and unlimited. Most of the ear, nose and throat work is given in English, although one can get better results if he has a working knowledge of German. Although it was hard for an Irishman like

me to become sufficiently acquainted with the language to "get by," I finally succeeded to such an extent that I could read such important literature as the menu cards and could differentiate a Wiener schnitzel from a Wiener wurst. I had intended writing a few words about the clinics of Vienna, but since I had the misfortune to mention "Wiener Schnitzel," and not being able to get one, I am so filled with grief that I must repair to some lunch counter for consolation.

Please send the JOURNAL from now on to 228 N. Main St. If you are ever up this way remember that the latch string is always out and it would please us greatly to have you as our guest.

With kindest regards, I am,

Yours truly,

JOHN H. DOYLE.

HILLSDALE, PA., August 10, 1911.

Dear Doctor Brack.—Enclosed find check for two dollars, my subscription to the Journal for 1911 and 1912. I enjoy the Journal very much as it is the only means I have of keeping in touch with the "boys" whom I knew there.

Fraternally yours,

E. E. HEILMAN, '93.

Portland, Oregon, Aug. 23, 1911.

Dr. Chas. Emil Brack, 500 East 20th St., Baltimore, Md.

Dear Doctor.—Enclosed find express money order for one dollar for subscription to the Journal for 1911. Also please change my address from Arleta, Oregon, to 5611 Foster Road S. E., Portland, Oregon, and oblige,

JNO. R. ROBINSON, '01.

ATHOL, CATONSVILLE, MD.

CHAS. EMIL BRACK, M. D.

Dear Doctor Brack.—Herewith find \$2.00 for 1911-12 subscription for the Journal. I enjoy reading the Journal as it gives me information regarding the boys which I could not otherwise obtain.

Very truly yours,

THERON E. ROE, '10.

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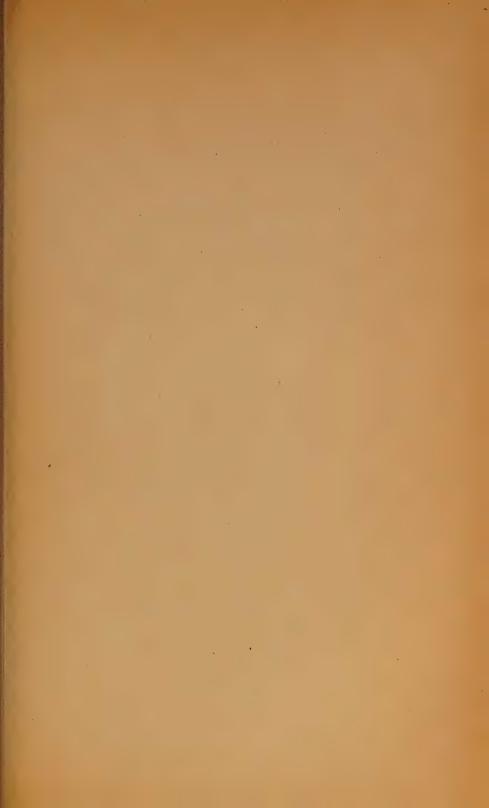
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# THE JOURNAL

OF THE

### ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS AND SURGEONS

BALTIMORE.

Vol. XIV

No. 4

JANUARY, 1912

PUBLISHED AT Greenmount Avenue & Oliver Street Baltimore, Md.



# Class of '75

# Reunion in First Week of June, 1912

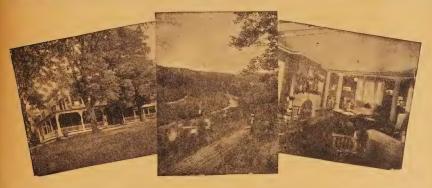
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ON PAGE 122

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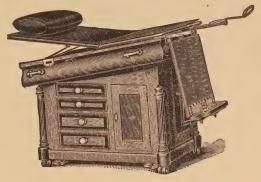
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BALTIMORE.

# FIBRO-MYXOMA AND MYXO-SARCOMA OF NERVE SHEATH.\*

BY ALEXIUS McGLANNAN, M. D., BALTIMORE, MD.

The fibro-myxomatous tumors present problems of interest to both the surgeon and the pathologist. The surgeon must study them with regard to the extent of operation required for their removal and complete cure. The pathologist finds a field for study in their origin. To both the malignant character of some original and other recurrent tumors opens an interesting field for study of the essential malignancy of tumors or the possibility for their acquiring this change in nature.

These tumors occur most often in the skin or subcutaneous tissue, frequently as intermuscular growths, or deeper on the large nerve trunks. They occur especially in connection with the submucous tissue of the nose, pharynx, and digestive tract. In these last mentioned localities the tumors are usually polypi, covered with epithelium, the cells of which may be secreters of mucus. This, however, is not the source of the myxomatous material of the tumors.

The essentials of structure of a fibro-myxomatous tumor are loose meshes of fibrous tissue surrounding areas of clear gelatinous material in which are seen branched connective tissue cells. The gelatinous material is the myxomatous intercellular substance. With the branched cells the tumors contain varying numbers of round and spindle cells and fibroblasts. According to the number and predominance of any of these cells, the tumor is relatively more or less malignant or benign. That is,

<sup>\*</sup> A study based on the collection of these tumors in the laboratories of surgical pathology in the Johns Hopkins Medical School, and in the College of Physicians and Surgeons, Baltimore.

a tumor containing few young connective tissue cells is benign, while one rich in these cells is malignant; and the degree of malignancy varies with the predominant cell. One essentially round celled is more malignant than a spindle cell one, while the fibroblast and fiber means even less malignancy.

The myxomatous tissue in these tumors is probably a degenerative product. This view is reflected in their nomenclature—eedematous fibroid, fibroma mucinosum, colloid fibroid, gelatinous fibroid are names applied by different pathologists. The structure of this portion of the tumor is very similar to that of the tissues in elephantiasis, and it is reasonable to suppose that its origin is the same, namely interference with lymphatic circulation. The eedema may pass on to the formation of cystic or lymphangiectatic cavities. The eedema of the small tumors of nerve sheath is explained by obstruction of the lymphatics of the nerve, a system distinct from that of the tissues it traverses. (Adami, p. 716.)

Tumors of the peripheral nervous system may arise from the axis cylinder process, or the coverings of this structure. Tumors of axis cylinder, i. e., (neuroblastic) origin (pure neuroma, ganglion neuroma) are very rare, and when they do occur, almost always originate in the sympathetic ganglia. Tumors of the coverings are more common, and may arise from any of the sheaths of the fiber, bundle or nerve trunk. It is the generally accepted view that the nerve sheaths are of connective tissue (mesoblastic) origin, but Adami (General Pathology, p. 760) quotes Verocay to prove that the cells of the Sheath of Schwann are of neuroblastic origin, and consequently that any tumor derived from this sheath is a neurinoma. In further proof of this neuroblastic origin of the sheath, Adami calls attention to the occasional presence in these tumors of cells of neuroblastic origin, varying from the small round neurocyte, which resembles the lymphocyte, to imperfect neuron types. He explains the fibrous elements as the result of a fibrosis, like that occurring in the development of scirrhus carcinoma. This theory of Adami's is attractive because, if pushed to the limit of its application, we could include it in all of our fibro-myxomatous tumors as neuroblastic growths. It is especially applicable to the myxomatous tumors of the pharynx and those multiple ones in the gastro-intestinal walls, occurring both with and without similar growths of the subcutaneous tissue. The

ganglion cells of the sympathetic would furnish points of origin for any of these tumors, if we admit the neuroblastic origin of the Sheath of Schwann.

Various subdivisions of nerve sheath tumors are described, and numerous synonyms confuse the nomenclature. Two important varieties are recognized, von Recklinghausen's disease and plexiform neuroma. The other nerve sheath tumors are best classed in a third group, having less distinctive characteristics.\*

Plexiform neuroma is a mixture of true neuroma with fibroma of nerve sheath. The number of nerves and their length is increased. As a rule there is elephantiasis, pigmentation or other change in the skin area of cutaneous distribution of the nerve involved. These tumors may be multiple along a single nerve or several may occur on different nerves. They may occur also on the nerve roots within the vertebral canal. Bland Sutton (Tumors, 3d edition, p. 143), records a case in which paraplegia and death occurred from such a tumor in the cervical region. Sarcoma may develop in this variety and the cure of either the benign or malignant form requires the removal of a portion of nerve sufficiently great to insure the complete excision of all involved tissue. The multiple nature of the growths, therefore, may require the most extensive resection and lead to extremes of neuroplasty in order that the function of the part be restored.

Case 8478, multiple fibromyxomas, is a benign plexiform neuroma of the lateral twig of the twelfth thoracic nerve.

von Recklinghausen's disease, as described by himself, is a condition of multiple neuromas associated with cutaneous fibromas. The so-called neuromas he described as nerve sheath tumors, the axis cylinders having no part in the growth. The tumors of the nerve stem, or of the cutaneous endings, may predominate in different cases. These tumors are usually small, as a rule remain benign, and are generally free from pain or tenderness. Occasionally one or more become quite large, one or more may be pain-

<sup>\*</sup>The distinction between von Recklinghausen's disease and plexiform neuroma is not well defined. In both conditions there are tumors of nerve sheath, with changes in the skin. Frequently, developmental defects, as spina bifida, etc., are associated with von Recklinghausen's disease. The skin in both conditions shows pigmentary change and elephantiasis, that is, a condition of lymphatic ectasia, with chronic inflammation.

ful. Unusual local growth of one of the tumors is an indication for its immediate removal on account of the probability of malignant change. When quiescent, however, they need not be interfered with except for cosmetic purposes. A large growth should be excised to give greater comfort or to prevent ulceration; a painful one should be removed in order to get rid of this symptom. The operation is excision, never enucleation.

The third group includes both single and multiple tumors. In the series studied for this paper there are twenty single and six multiple tumors. Two of the single ones recurred locally as sarcoma. Two multiple cases returned with local recurrence of multiple benign tumors and were cured by complete excision. Apparently, therefore, single tumors are more likely to become sarcoma than are multiple ones.

Single Fibromyxoma.—The tumors of this group seem to arise irregularly from any of the connective tissue sheaths of the nerve. A number of them seem to be from the epineurium alone, because in these cases the growth could be separated completely from the trunk.

Clinically they are seen as swellings of different sizes in various positions. The age of the patient, duration of the tumor and other clinical features are shown in the tables. There was no case in which paralysis occurred. In both cases where recurrence took place pain and tenderness were noted in the clinical course of the original growth. No nerve fibers were found in the original tumor from the recurrent cases. It is my impression that these tumors having pain or tenderness as a symptom are growths from the neurilemma, endoneurium or perineurium rather than the epineurium, and that when such growths occur in a large nerve, excision, leaving the nerve trunk, is an incomplete removal and will be followed by local recurrence with great probability of malignancy in the recurrent tumor.

Ganglion.—Case 9137 is of interest because of the light it throws on the pathology and nomenclature of ganglion. Billroth taught that a ganglion is a hernial protrusion of a synovial sheath or capsule, later on separated from the original cavity. Ledderhose described a ganglion as a myxomatous tumor in which focal areas of degeneration form small cysts that later coalesce to form a single cavity. Custodius (Beiträge zur klin. Chirurg., 1904, vol. XLIII, p. 788) reports a case in which

degenerated nerve fibers were found in the wall of a ganglion, excised from the peroneus nerve. The patient gave weakness of the muscles and sensory disturbance as the symptom of onset.

Case 9137 is a similar tumor from the extensor surface of the foot, near the ankle, probably originating in the gangliform enlargement on the external terminal branch of the anterior tibial nerve. This tumor on section showed a central cavity of cystic degeneration, the walls of which were fibromyxomatous tissue.

Case 7917 is a recurrent tumor that was originally diagnosed ganglion and treated by means of a sharp blow. Recurrence took place in six months and this tumor was removed one and one-half years later. It is an encapsulated spongy mass, very like a simple goitre in its gross appearance. Histologically it is hemorrhagic fibromyxoma.

Multiple Tumors.—In this group we have the interesting plexiform-neuroma and von Recklinghausen's disease. One of the former, Case 8478, and two cases of the latter, 4607 and 8643 are included in the table. In case 4607 (von Recklinghausen's disease) one hundred and thirteen tumors were removed at intervals. The growths are rarely painful and seldom tender.

The multiple enlargements arise from different nerves, or from several points along one nerve trunk. This latter feature is important when one of the tumors becomes definitely malignant. Similar change may be expected in other nodules, and therefore extensive or multiple resection will be required.

Case 6957 is an interesting one reported by Dr. Brickner (American Journal of Obstetrics, Vol. LIII, Nov. 2, 1906) fibroma molluscum gravidarum, a condition characterized by the occurrence of multiple fibro-myxomatous tumors of the skin of the neck and mammary region. These tumors develop during the latter half of pregnancy, but disappear spontaneously within six months after parturition. Histologically they are cedematous fibroids and do not contain nerve fibers. This condition is more like molluscum contagiosa than von Recklinghausen's disease, but is noted here on account of its rarity and general resemblance to the tumors under discussion.

Malignant Fibro-myxomatous Tumors (Myxo-sarcoma).—We have twelve cases in the table, ten single tumors and two multiple. Two cases

(3981 and 022) were recurrent, following an apparently benign tumor, which was removed without excision of the nerve involved. Both were of long duration and it is likely that the sarcomatous change is in accordance with the principle that tissue which has developed in excess of function is liable to take on aberrant growth.

Case 4382 is one in which there were multiple tumors of the sciatic nerve and its branches. The growth in the popliteal space was not recognized until symptoms had been present one year. These were numbness and tingling, at first noticed only when the leg was extended; later, these sensations were present all the time and changed to burning and itching. At the end of the year there was a definite loss of motion in the muscles supplied by the internal popliteal nerve, with corresponding sensory disturbance. This condition must have been present during the last five months of the year, because the patient had been treated for flat foot for this length of time. The swelling was palpable in the popliteal space at a point which had been tender six months.

At operation, the tumor and both popliteal nerves were excised. In eight months there was recurrence with multiple growths in the nerve above the line of excision. The recurrent tumor infiltrated the muscles. The leg was therefore amputated below the trochanter. The entire sciatic nerve in the leg was nodular and was removed. There followed a free interval of four years, then signs of local recurrence and the patient died in a few months. The post-mortem examination showed local recurrence of the tumor in the stump, with direct extension into the iliac glands and metastasis to the liver.

This case is an example of malignant change in one of the several tumors of a nerve sheath, followed by a similar change in the character of the remaining tumors. Therefore in operating for sarcoma of nerve sheath the nerve trunk should be exposed through as much of its extent as is technically possible, with complete removal of all tumors seen. After operation these patients must be carefully observed for at least four years, and immediate operation performed at the onset of signs of nerve pressure or other symptoms of tumor.

The mortality in sarcoma of nerve sheath is high. Six of the twelve cases are dead; two have been operated on within the last year, and it is therefore too soon to count them among the cured cases.

The cured cases were various forms of cellular sarcoma and were treated in different ways. As is the general rule, the extent of operation required was only sufficient to insure complete removal of the tumor. Case 5428, histologically a myxo-fibro spindle cell sarcoma, only slightly cellular, was cured by curetting. Case 6207 required amputation because the tumor had infiltrated muscles to such a degree that its complete removal was impossible by any other method. This tumor is very like 5428, but had been incised several times, leaving a sinus before coming to the final operation.

Cases 9654 and 10251 are of interest because the employment of angioplasty and neuroplasty in their treatment made it possible to completely remove the tumor and at the same time preserve the limb.

9654 is the case of sciatic sarcoma operated on by Dr. K. A. J. Mackenzie, of Portland, Oregon, and reported in detail by him in the Annals of Surgery, July, 1909, Vol. L, p. 295. In this report Mackenzie gives an excellent resumé of the work of Sherren, Rivers and Head, on the regeneration of nerves. He quotes these authors with regard to the nature of the afferent fibers of peripheral nerves and the variations of sensibility, dividing this into deep or pressure, protopathic and epicritic. As might be expected the coarsest pressure sensibility is the first to return in regeneration of nerve. The restoration of the protopathic form, that is cutaneous sensibility to pain, and to extremes of heat and cold depends on the regeneration of a system of fibers connecting end organs, which takes place rapidly after successful operation for repair of a divided nerve. This restoration is of the utmost importance, because by it trophic disturbances are cured or prevented. Epicritic, i. e., sensibility to light touch and fine variations in temperature is very slow in returning.

Mackenzie's patient had multiple fibroma molluscum (von Reckling-hausen's disease). One of these tumors, situated above the inner condyle of the humerus, was removed nine years before he came under this surgeon's observation. The condition of his hand at this time showed that the ulnar nerve had been divided in the removal of the tumor. The sciatic growth was first noticed, in May, 1907, as a small, painful and tender swelling in the middle of the back of the right thigh. After two months the pain disappeared to return in December, 1907, following

traumatism. This pain accompanied rapid growth of the tumor. The patient came to Mackenzie's clinic in January, 1908. At that time the man was unable to stand or walk on account of pain, the swelling was as large as a goose egg and very tender, the pain on pressure being transmitted down the leg and over the foot. There were scattered areas of hyperæsthesia and anæsthesia on the leg.

At the operation the tumor was found involving the sciatic nerve, but limited to this structure. For its complete excision the nerve was taken from the lower border of the gluteus maximus to one inch below the apex of the popliteal space. The segment removed was ten and three-quarter inches long. The small sciatic nerve was not recognized at the operation, but the area of anæsthesia following showed that it had been divided, although every effort was made to preserve all visible branches. The wound healed primarily, but the leg was paralyzed and showed distinct trophic change in the skin.

At two succeeding operations, performed three and six weeks after the first, the gap in the sciatic was bridged by flaps of nerve taken from the popliteals.

The end result, one year and four months after operation, shows no recurrence of the tumor and nerve recovery as follows: Trophic recovery complete, great return of epicritic, extensive return of protopathic and almost universal recovery of deep sensibility. The motor recovery is complete in the thigh and nearly so in the leg. The foot drop that made the foot helpless at first has disappeared, and while the flexors and extensors do not move the foot, they control it, preventing the drop. Muscular sense is unimpaired and the patient has independent and unaided locomotion.

Case 10251 is a sarcoma of the internal popliteal nerve in the popliteal space. This patient was operated on by Dr. Halsted, who found the tumor involving nerve, artery and vein. In the excision it was necessary to take a portion of each of these structures. The gap in the artery was closed by insertion of a piece of saphenous vein. No attempt at nerve suture was made. The patient recovered with a useful foot, having loss of protopathic sensibility, limited to an area on the sole of the foot, from in front of the heel to the great toe.

From the foregoing it is evident that a fibromyxoma of nerve sheath

TABLE I.-FIBROMYXOMA (SINGLE TUMORS).

Ultimate Result	Cure 20 years.	17	16	10 11	Died 3 mos. (Malignant	Local recurrence, see	Cure 1 year.	Cure 6 years.	Cure 4 years. Lost track of. Cure 4 years. Lost track of.	Cure 3 years.		Cure 1 year.	Recent case.	Cure 3 years. Local recurrence, see	sarcoma 0.22
tesult	rimam.	• :	3	3	:	:	;	:	::::	3	:	3	;	::	
liate B	g per p	::	:	:	3	<i>:</i>	3	3	::::	;	3	3	:	::	
Immediate Result	Healing perprimam.	::	t	ŧ	:	:	:	:	::::	:	:	3	3	: :	
Ætiology Extent of Operation	Complete excision.	* *	Excisionwithnerve.	Complete excision.	Tonsillitis Excision with sheath, from visible nerve.	Excision of encapsulated tumor.	Excision.	3	" (cocalne).	99	Excision with nerve	Excision with wide	Excision with some	Excision. Enucleation.	
Ætiology	¢~ ¢~	6-6-	6~	Trauma.	Tonsillitis	6	٥-,	۵.	Trauma.	e	0	<i>~</i>	6-	e→ e→	
Other Clinical Symptoms	None. None.	None. Pain and	Pain and	Pain and	numoness. None.	Radiating pain.	Pain.	None.	Pain. None. None.	Pain on use.	Tumor.	None.	None.	None. Pain.	
Sex Color Symptom of Onset	Tumor. Tumor.	Tumor. Tumor.	Tumor.	Tumor.	Tumor.	Tumor.	Tumor.	Tumor.	Tumor. Tumor. Tumor.	Tumor.	Loss of	Tumor.	Tumor.	Tumor. Tumor.	
Color	₩.	₩.	₩.	₩.	₩.	₩.	W.	W.	± ± ± ± ± ±	₩.	₩.	`.	W.	₩.	
Sex	Ä.	FiE	M.	W.	E.	M.	M.	M.	ZFF.X	M.	M.	M.	M.	KK	
Position of Tumor	Axilla. Chest wall under	edge F. Maj. Neck below l. jaw. Axilla.	Back over 11th rib	R. groin above and	Delow Fouparts. Leftsupraclavicular fossa.	Sciatic, near popli- teal space.	R. forearm.	Scarpa's triangle	Subsections. Subsections. Base thumb. Right arm. Axilla (subcutane-	Foot, between e. mal.	Sciatic, near hip.	Back (lumbar re-	Neck, below angle of	Finger. Abdom. wall above ing. canal.	
Age of Duration	3 years	.: 8	10 "	1	14 "	;	;	es :	::::	; «	11/2 "	6 жеекв	2 mos.	e- e-	
Age of Onset	286	27	31	80	27	36	25	30	8848 800 800 800 800 800 800 800 800 800	18	11/2 yrs.	88	37	88	
No.	179	752 1222	1242	1726	2874	3981	4423	6194	7917 8207 8585 8806	9137	9430	10299	10542	9862 Y111	

# TABLE II.-FIBROMYXOMA (MULTIPLE TUMORS).

	!						
	Type of Tumor	Fibromyxoma,	von Reckling-	See text.	Fibromy xoma.	\$	Plexiform neuroms.
	Ultimate Result	Cure 11 years.	No	Cure.	Cure. Lost track of.	Cure.	Lost track of.
	Immediate Result	Healing p. p.	3	Spontaneous	recovery. Healing p. p.	:	:
	Extent of Operation	Excision of fat and Healing p. p. Cure 11 years. Fibromyxoma. less.; cutan.	8 i. costal nerves. Excision of 118	Pregnancy Excision of one	Excision.  Excision of one tumor.	Excision.	Excision.  Excision with surrounding c. t. and a bunch of nerves
	Ætiology	6	6	Pregnancy	0	6.4	6-
The state of the s	Other Clinical Symptoms	Pain and tenderness.	Occasional	None.	None.	None.	Pain and tenderness.
	Symptom of Onset	Tumor.	Tumors.	Tumors.	Tumors.	Tumors.	Tumors.
	Color	₩ .	B.	W.		W.	¥¥.
	Sex	Ē	M.	뇬	M.M.	M.	ÄH.
	Position of Tumor Sex Color Symptom Other Clinical Etiology	Axilla, chest wall and F. W. Tumor. arm to elbow.	4607 Con- 24 years. All over body.	Neck and chest.	Angle of scapula, neck over thyroid,	Tyears. Recurrent multiple, M. sole of foot.	Sole of foot. Crest of ileum and l. F. buttook.
	No. Age of Duration	Recurrent A 1 year.	24 years.	:	3 years.	7 years.	16 years.
	Age of Onset	30	Con-		33	13	11,
1	No.	2358	4607	6957	8101 <b>6</b> 854	8103	88343

TABLE III. -SARCOMA (FIBROMYXOMATOITS) OF NERVE SHEATH.

	1	1	nd	a,	,	-0.1	ell	æ.	-0.	ell	oğ.	-11	-0	**0
	Ultimate Result and Type of Tumor	Death, 2 yrs., metastasis.	See text.—Myxo-round and s. cellsarcoma.	Partial excision Died 2 months Fibro-spindle cell sarcoma.	Teratoma-s. cell sarcoma.	Cured 7 years Myxo-fibro-	s. cell sarcoma. Cured 7 years.—Fibro-s. cell	sarcoma. Myxo-spindle cell sarcoma.	R. and spindle cell myxo-	sarcoma. Cured 4 mos.—Fibro-s. cell	myxo-sarcoma. Being treated by ColeyS.	Fungus ulcer. Death 14 mos.—R. cell sar-	Coley toxins, coma, Local recur- Death, 8 mos., general me-	rence, 8 mos. tastasis. R. cell sarcoma. Healed, p. p. Lost track of.—S. c. myxo-sarcoma.
TABLE IIISARCOMA (FIBROMYXOMATOUS) OF NERVE SHEATH.	Immediate Result	Healed p. p.	Excision, nerve Healed p. p.	Died 2 months		Healed by	granulation. Healed p. p.		See text.			Fungus ulcer.	Coley toxins.	rence, 8 mos. Healed, p. p.
	Extent of Operation	Extent Immediate Cof Operation Result Local excision. Healed p. p.		Partial excision	Partial excision Died.	Curetting.	Amputation.		п	angioplasty. Wide excision. Healed p. p.	Exc. of tumor & Healed p. p.	glands or groin Incomplete	excision.	
	Primary Single or Sex Col. Symptom Other Atiology Recurrent Multiple			0-	6-	۵.	6-		<b>~</b>	۵.	Trauma.	Benign	tumor.	Excision.
	Symptoms	Radiating Benign	Tumor,	None.	None.	Tumor.	Tumor.		Tumor.	Pain.	Pain.	Pain.		
	Symptom of Onset	Single. M. W. Tumor.	Pain and paral.	M. W. Tumor.	Single. F. W. Tumor.	Pain.	Single. F. W. Radiating Tumor.	pain.	Pain.	Tumor.	Tumor.	Tumor.	M. W. Tumor.	Tumor.
MA	Col.	W.	¥.	W.	W.	W.	W.	cas	B.	W.	×.	M. W.	W.	W.
RCO	Sex	M.	F	M.	Œ.	Œ,	퍈	ie's	M.	M.	M.	M.	M.	M.
4 III. –SA	Single or Multiple	Single.	Primary. Multiple. F. W. Pain and Tumor, paral. tender.	Single.	Single.	Multiple. F. W. Pain.	Single.	See text Mackenzie's case.	Single. M. B. Pain.	Multiple.	Single. M. W. Tumor.	Single.	Single.	Multiple.
TABL	Primary or Recurrent	2 yrs. Recurrent	Primary.	:	;	=	3	See text.	Primary.	Recurrent Multiple. M. W. Tumor.	Primary.	Recurrent	Primary.	Primary.
	Position of Tumor	Popliteal space and b. of thigh.	Popliteal space and b. of thigh.	Lumbar fossa.	Con- 3 mos. Ischio-rectal	Coccyx region.	4 years Popliteal space.	Sciatic, middle	261/2 4 mos. Popliteal space.	leg.	Groin (ant.	wall (lleo-	Sciatic.	Popliteal nerve. Primary. Multiple. M. W. Tumor. Pain and spasm.
THE RESERVE AND PERSONS ASSESSED.	Dur- ation	6 years Popl	1 year Popl	2 mos.	3 mos.	3 years	4 years	2 years Sciat	4 mos.	3 years Left	5 mos. Groin	4 mos.	~	6 wks. Popl
	No. Age of Dur- Onset ation	98	253	63	Con-	19	33	43	261/2	46	F-0	62 4	30	45
	No.	3981	4382	2547	8709	6428	6207	9654	10261	10801	11064	0 22	0116	0 438

requires complete removal for its cure. As it is impossible to determine clinically, or at operation, from which sheath of the nerve the tumor arises, the only certain method of complete removal includes excision of the area of nerve to which the tumor is attached. The gap in the nerve should be closed by immediate neuroplasty. Involvement of vessels by the tumor does not necessitate amputation, when angioplasty is possible. Infiltration of muscle requires amputation, or complete removal of the muscles involved. These tumors are frequently multiple in the course of a nerve, therefore whenever a malignant tumor of nerve sheath is removed, the entire nerve trunk should be examined for other tumors and these also excised. Disturbance of motor or sensory function, associated with a tumor of nerve sheath, gives strong probability of malignancy, certainty of involvement of the inner coats of the nerve, and is sufficient indication for the excision of nerve in the removal of the tumor.

### WHAT THE MEDICAL MAN OWES TO HIMSELF.

BY JOS. W. MALONE, M. D., '88, OF BROOKLYN, N. Y.

I have used the term "medical man" because it refers to the three classes of men who are engaged in the calling of administering to the wants of the human body, viz.: the physician, the dentist and the pharmacist.

For the sake of brevity I shall use the term physician in this paper, but what I have to say will refer equally as well to the dentist and to the pharmacist.

Much has been said and written about the obligations of a physician to his clients but there is one class of obligations that has been greatly overlooked. This is the question of the physician's duty to himself.

In the first place there is nothing in the fact that a physician who has worked to acquire a medical education owes the world a life time's debt in consequence. The young man who contemplates the study of medicine for his life's work, should carefully examine himself as to his fitness for such a calling. There are many men who take up the study of medicine who are not fit for such work and should be persuaded not to undertake it. And first it might be well to inquire what are the physical conditions a man should have who contemplates such work. He should examine

himself very carefully as to his physique. He should have a good, healthy, strong constitution; one capable of endurance. His body should be well developed. His muscular, nervous and digestive systems should be as near perfection as possible. He must have a good education and he must be an apt and quick student. While it is desirable that he should have a college education, I do not believe that it is absolutely necessary, but I do believe he should have more than an ordinary education. He should have a business education so that he will be able to know how to take care of himself and family. These questions being settled, he commences to prepare himself for his life's work.

He should be systematic, he should find time for study, work, sleep and recreation,

The physician's first duty is the same as that of everyone else. It is to make the precious gift of Life well worthy of the Giver. To do this, he must not forget that the development of his own powers and possibilities is a sacred trust, and that the penalty of its neglect will surely be the waning of these qualities. At every step in his work he must ask himself "is this best for me," and, being so, if he remains true to himself, develops his powers for good, his very acts will cast an influence for good to those with whom he comes in contact. He is watched, not only by his patients, but the people of the community in which he lives and he must ever keep alive "that little spark of celestial fire, 'conscience'."

The most common crime the average physician commits against himself is that of over-work. Long after his weary nerves and aching muscles cry for rest, the whip of "must" keeps pushing him on until there is a break-down and he must rest whether he wishes to do so or not.

Too many physicians make the mistake of carrying all the load of anxiety on themselves. They do not often enough keep the family and friends apprised of the real danger of a serious case they may be attending for fear of upsetting the equilibrium of the family and when the fatal crash comes, as it often does, he is blamed for not telling them of the danger to the patient, or, if he does tell them, he does not make it emphatic enough.

He owes it to himself to call in consultation some other colleague and thus divide the responsibility. This is not done often enough in my opinion.

The physician owes it to himself not to overdraw his health account. This is his most valuable asset. He must have a clear mind, a rested body so as to carry on his hard and arduous work. He should take and get all the rest he can and even if social duties are irksome he should not refrain from them.

He should take a vacation of at least four to six weeks every year.

I know there is the old worn-out cry, that he cannot afford it, that his patients will drift away from him and many other such hoodoos. Well, let them go then. If his patients do not think enough of him to allow him to recuperate his worn-out and tired body by a good rest, he is better off without them. If they will leave him for this cause, they will leave him whether he stays at home or not. And, when the crash comes—as come it will, the self-same patients will be the first to say "Well, there was Dr. So-and-So. He just killed himself by over-work. Kept at his post and would not take a rest."

The physician owes it to himself to know when to retire from active work. He should prepare for old age and lay by some means upon which to live when that time comes. As he grows older in practice he should find a way to get larger fees, for his experience entitles him to this.

He owes it to himself to take, at different times, post graduate work. He should visit the different hospitals and post graduate schools and take up a course in some branch of study in which he feels he is deficient. Nothing helps him more than to have it known among his patients that he is taking such a course. By becoming more expert in a certain branch of his profession, he can assure his patients he is better prepared and he can demand larger fees. He must always remember that there is plenty of room at the top.

It has been notoriously said that the physician is not a business man and this statement has more than a grain of truth in it. When a man gets a call to see a new patient, in a family he does not know, he flushes with pride that he has secured a new family among the clientèle, but how few men stop to inquire anything about the family or the man who pays the bills. He should make inquiry as to the man's business, his ability to pay, or whether this same man does not owe some colleague of his a large bill and has changed his physician only to treat him the same way.

Why should the physician sell his knowledge and ability without knowing whether he will secure his pay for such work. The business man will not sell a bill of goods without making some inquiries about when the bill will be paid. The physician can do the same. He must be more diplomatic about it, but it can be done. When he makes his first call to a new family he can say to them, in a way which will not offend, something like this, viz.: "My fee is two dollars; I am a stranger to you, and if agreeable, I should like my fee, etc." This will always bring the money or an arrangement for payment, and by this means he can then judge whether he has secured a good or bad debtor. He should be prompt in sending out his bills and watch closely that these bills are paid. "Short settlements make long friends" is an adage which is a good one. He is better thought of when he gives his patient to understand he expects and wants his money. When a man asks for his bill, give it to him at once and keep your books so you can know at a glance what amount is due. It is the height of foolishness to send bills out quarterly and wait several years for the payment of them. Close collections enable a man to pay his own bills and lay something by for his permanent investments.

This brings up the question of investments—a most important on to the medical man.

When a man comes to you with some scheme for investments, listen to what he has to say—don't ask questions but let him do all the talking. If he has a good thing you will be able to analyze it to your own satisfaction. The schemer wants you to ask questions, and if the scheme is a good one he cannot "talk it dry," but if a bad one he will soon talk himself out and you will then be able to judge its worth.

The medical man owes it to himself to be very careful concerning his entering into some stock company by buying stock when the other fellow has control and can freeze him out. Thousands of dollars have been lost that way. For investment we want something that is permanent, something that can be sold in a ready market if necessary, and thus get the true value. We should steer clear of any scheme or company that offers a big per cent paid as dividends and be content with something more reliable even if less remunerative. It is harder to get the first \$1000 together for an investment than the next \$1000, and a man should look well and long into anything whereby that first hard-earned savings should be invested.

I want to say a word about the attitude of the patient to the physician. Ours is the noblest calling on earth. We are called into homes and for the time being we are one of the family. We learn, more or less, the family secrets. We see many times the "skeleton in the closet," and we owe it to ourselves to so conduct ourselves that the patient treats us not only as a man to relieve the physical pain but to look upon us as a friend, counselor or brother. We cannot always keep death from our midst, but we can and do prolong life and stay the "grim reaper" for a time.

The life of a physician is a hard one. It means long hours and tedious, hard work at best. The true physician never rusts out but wears out, and many of us go long before our time, but we have the pleasure and satisfaction of doing good and helping others, and if we do our best and have a clear conscience of doing our utmost, we have a reward that is not forgotten even after we have passed away.

Consideration of self is not selfishness. True philanthropy enables one to do better work and better deeds to others by knowing the needs of ourselves. Let us learn to know ourselves—our faults—our shortcomings; for by doing so we can command a far greater respect from our fellow-men.

It is far better for us to plant an acorn which will grow into an oak of a century and a forest of a thousand years, than to sow a thousand morning-glories which bloom in the morning and are wilted at night.

So it is far better for us to take care of our body, both mental and physical, in order that we may be the means of doing great good and when at last we come to the end of our journey and have laid down the working tools of life, we shall receive the reward which cannot be taken away.

## THE FAMILY PHYSICIAN AND THE CLAIM BLANK.\* By W. EDWARD MAGRUDER, M.D., BALTIMORE, MD.

The scope of the successful claim adjuster for accident and health insurance companies is broad, but the limits are well defined. He stands between the policyholder and the company as a referee and adviser doing

<sup>\*</sup>Read before the International Claim Association, Annual Meeting, September, 1911, Old Point Comfort, Va.

justice to both and remaining, under all conditions, true to himself. He seeks the truth regardless of whom it hurts, carefully weighs the facts in the case in their relation to the policy conditions, and then endeavors to make the adjustment by meeting the full liability which his company has incurred. He has no easy berth, for his path in search of the truth is beset by many obstacles, and his efforts to satisfy the claimant within the limit of indemnity to which he is actually entitled are often opposed by the claimant's misconception as to policy requirements, as well as by the only too natural tendency of the injured party to exaggerate his disability. Fortunately, the honest adjuster meets many compensating conditions for, in spite of the frequency with which he finds apparently unreasonable claimants, he likewise becomes impressed with the fact that there is good in every man if it can only be reached and that all men with whom we come in contact are lovers of a square deal and most of them are willing to meet it at least half way. Few claimants, when properly approached by a fair-minded adjuster and told the truth derived from a proper investigation of the facts surrounding their claims, but will listen to reason and become satisfied with the amount which is actually due them. Of course, they will resent arbitrary and partisan treatment, but who would not? Claimants, on their part, have some prejudices to overcome, sometimes against insurance companies as a class, sometimes because they have an idea that corporations are all heartless, and sometimes as the result of some previous claim experience when, either through bad methods of adjustment or on account of their misapprehension of facts, they arrived at the opinion that they had been unfairly treated.

The most important single barrier interposed between the adjuster and the true facts for which he seeks is the family doctor.

While the attitude of attending physicians toward insurance companies and their claim blanks has been held responsible for the large proportion of the claims which are unjustly paid, it must be said in behalf of the medical profession that these physicians are not wilfully dishonest and their sins are more often due to omission than to commission, to misunderstanding, rather than to deliberate action following careful consideration.

The claim blank is usually placed before the family doctor at his

patient's bedside, often during the busiest hours when other, and to him more important duties, are pressing hard upon him. How natural it is for him to copy the claimant's answers which he usually finds have been made upon the reverse side of the blank or to passively lend himself to the suggestions of his patient concerning the data which the company requires! How perfunctorily he dispatches the tedious duty before him!

In some cases, no doubt, the physicians are controlled by other, but no less natural motives. They may themselves be alarmists, considering all their patients very ill and with habitual inclination to take a gloomy view of their patient's condition, give it expression in their claim reports. Then, again, physicians are often so hard pressed in meeting competition and satisfying and holding their patients that they fall into the habit of taking the line of least resistance whenever possible and upon such an unimportant matter, as the filing of claim blanks appears to them to be, easily accede to their patient's wishes rather than cause a conflict. They may even go so far as to make a prominent symptom stand in place of a disease, or otherwise shape the diagnosis to suit the policy conditions without actually realizing that they are doing wrong. In some instances, the attending physicians, no doubt, have acquired an incorrect impression concerning insurance companies, believing that they are prone to dodge their obligations to their policyholders, and, as protectors of their maltreated patients, they feel constrained to assist them in getting full returns in the way of indemnity for any illness or injuries from which they suffer. While passively giving support to his patients in the collection of money to which they may not be entitled, under the policy conditions, the family doctor, as a general rule, derives no actual pecuniary gain. In fact, in the most conspicuous instances of so-called claim boosting by physicians, the doctors have done their work in much the same spirit as they give advice for the prevention of disease, entirely oblivious of self or of any personal benefit, and, most often, at risk of great sacrifice of time and energy in court attendance.

At heart the family doctor is not unlike the claimant, just as full of good intentions—perhaps a little more so, as his professional training well prepares his mind to recognize the truth when it is brought straight to him. How ready he usually is to square himself and tell the truth when confronted with the facts as they actually exist, and how different are

his statements under these conditions from those he may have made upon a claim blank previously filled at a patient's bedside! He is largely governed by circumstances and is honest but wonderfully human. Why should he be expected to constitute himself the company's adviser, giving positive information upon claim blanks when it may prejudice his patient's claim? Why not take the passive course and tell part of the truth and that sparingly? He usually does, and for reasons above described, only naturally so.

Granting the indisputable facts that claimants and their family doctors while prone to make demands upon insurance companies in excess of what the true conditions warrant, and that they are so full of good intentions that they can be counted upon to accept fair treatment when the companies show them that they want to meet their liabilities in full, how can we be placed in better position to acquire the truth in relation to claimants and their disabilities and thereby to promote the feeling of mutual confidence between the companies, the claimants and the adjuster who stands between them?

Some of the practices which appear helpful to some accident companies, and should prove equally useful to others, may be described as follows:

- 1. More care should be used in the selection and training of medical examiners for the companies. Men should be employed who are not only well trained physicians but who are temperamentally equipped to review the work of other physicians and make reports which impart the conditions as they actually exist. They should be able to interview other physicians when necessary, command their respect and by their fair treatment of the claimants and their doctors promote that degree of good feeling which brings things into their true relations. Such examiners if available could, with advantage, be called upon for assistance in a larger proportion of claim investigations than has been the custom in the past among most companies.
- 2. As claim blanks seldom contain the facts in their entirety or proper relation, claims paid upon them alone and without other investigation are usually incorrectly estimated and injustice is frequently done. Overpaying of claims through imperfect investigation is demoralizing to claimants, encouraging dishonest claims, and proves expensive to com-

panies as well as costly to conscientious policyholders who are compelled to pay unnecessarily high premiums to help cover such unanticipated losses. Failure to investigate claims carefully and pay them on their merit gives rise to needlessly high loss ratios and offers a temptation to claim departments to take advantage of technical defenses in order to make the business prove profitable.

- 3. A separation of the claimant's blank from that required from the family physician can with advantage be made in a greater number of cases. Such blank executed by the attending physician at his office and away from the influences previously described, and at his less busy time, is much more likely to contain the true facts than when filled under other conditions. It can often, with advantage, be sent or taken personally by the company's medical examiner or other representative to the family physician for his attention and, when impressed with the fact that the company wants only the truth and that the true facts will work no injustice upon anyone, the doctor seldom fails to furnish the information necessary for the consideration of the claim in its correct relations.
- 4. Effort should be made by accident companies to educate the public and the medical profession into a knowledge of the truth as we adjusters have come to know it, that companies stand ready at all times to pay the full liability which the policy and the facts in the case warrant and that they desire to meet squarely, and not avoid their obligations, to their policyholders.

## THE WASSERMANN REACTION FOR SYPHILIS.\* BY JOHN I. WISEMAN, M. D., KINGS PARK STATE HOSPITAL.

Within the past few years much investigation has been carried on and much written, both abroad and in this country, concerning a test for syphilis, now spoken of as the Wassermann reaction. The value of such a test to the general practitioner and specialist alike can scarcely be overestimated, if it is simple to perform, accurate and reliable in its results.

The purpose of this paper is first to give the fundamental facts from which the reaction developed, the reagents necessary, and technique required to perform the test; and second to describe briefly the Wasser-

<sup>\*</sup> Read before the Suffolk County Medical Society, April 28, 1910.

mann reaction as modified by Dr. Noguchi of the Rockefeller Institute for Medical Research.

The test, as devised by Wassermann in 1906, is based upon certain phenomena described by Bordet and Gengou in 1901. Bordet and Gengou found that if they injected into the circulation of an animal of one species (for instance a rabbit) the red blood corpuscles taken from an animal of another species (as a sheep) they could produce in the serum of the former a substance which would destroy the corpuscles of the latter. This was found to be equally true for a variety of animal and vegetable cells, especially the bacteria. The substances produced in the blood serum are spoken of as the immune bodies or anti-bodies, while the substances used to produce the anti-bodies (i. e., the substances injected) are spoken of as antigens.

The action of antigens and the production of anti-bodies can, perhaps, best be explained by a diagrammatic drawing representing Ehrlich's conception of immunity.

A cell is represented as having variously shaped receptors for combining with different kinds of substances. Antigen is attracted to the cell and becomes fast to a certain type of receptor, and being a poison it tends to destroy the cell; if, however, the cell is not destroyed it will be stimulated to form new receptors in large numbers which become free in the circulation. These are the immune or anti-bodies. While free in the serum they still retain their power to attract antigen and combine with it to form a neutral substance which is finally destroyed. It was found that when a serum containing anti-bodies against red blood corpuscles is heated to 56° C. for half an hour it loses its power to destroy or hemolyse the corpuscles. Serum thus treated is said to be inactivated. If a small quantity of fresh serum is taken from an animal in which anti-bodies do not exist and added to the heated serum then its power to cause hemolysis will be restored. This process is called reactivating the serum. But normal fresh serum alone will have no effect on corpuscles. This experiment proves that the destruction of an antigen by specific anti-bodies depends upon the combined action of two substances: one is produced by the injection of corpuscles or other antigens and is called amboceptor; the other is present in all fresh normal serum and is called complement.

Bordet and Gengou found further that if they added a culture of bac-

teria to a serum containing free complement and which was immunized to that particular species of bacteria, that a reaction would occur and complement would become fixed or neutralized. The serum then would be inactivated just as happened when the serum was heated to 56° C.

Let us now see how these facts can be utilized in a test for syphilis.

As the injection of sheep corpuscles into the circulation of a rabbit produces anti-sheep amboceptor so the presence of the spirochæta pallida in the circulation of a person infected with syphilis acts as antigen and produces anti-syphilitic amboceptor. To Wassermann is due the credit of first bringing together in a test tube a serum containing syphilitic amboceptor, antigen and complement, allowing them to combine at body temperature for half an hour and then testing for the absence or presence of complement. This latter process forms the second step of the test, and is carried out by adding sheep's corpuscles and anti-sheep amboceptor to the tube after the first reaction is complete. If in the first step of the reaction complement has been neutralized or fixed by the reaction between antigen and syphilitic amboceptor, the sheep's corpuscles will remain unaltered. This constitutes a positive reaction for syphilis. While on the other hand if syphilitic amboceptor is not present in the suspected serum then no such reaction can take place between antigen, amboceptor and complement and in the second step of the reaction complement will be free to combine with sheep's corpuscles and anti-sheep amboceptor and cause hemolysis of the corpuscles.

This constitutes a negative reaction.

The Wassermann reaction is divided into two steps, for the first are required patient's serum, complement and antigen. The patient's blood is collected from the lobe of the ear in a glass tube. After clotting one drop of the serum is placed in a test tube and one drop is placed in tube No. 2, which is to serve as a control. Complement is obtained by diluting the serum of a guinea pig with one and a half times its volume of normal salt solution. The guinea-pig serum must be perfectly fresh (not older than 24 hours) and kept on ice after the serum has separated. 0.1 cc. of this solution is added to the patient's serum in each test tube.

Antigen is an alcoholic extract made from normal liver, kidney or heart tissue which, according to the excellent suggestion of Noguchi, is dried on strips of filter paper and standardized so that a piece of known size is sufficient to combine with syphilitic anti-body and fix all the complement in the guinea-pig serum. The mixture is then placed in a thermostat at body temperature for one hour; this completes the first step of the reaction. At the end of an hour 1 cc. of a suspension of human red blood corpuscles in normal salt solution in the proportion of one drop of blood to 4 cc. of salt solution is added to each tube. Amboceptor against human red blood cells is also added. This is prepared from the serum of a rabbit that has been immunized to human red blood corpuscles, and here again Noguchi has dried this serum on strips of paper and standardized it so that a piece of definite length will completely hemolyze 1 cc. of the blood suspension within two hours. At the end of two hours the control tube will have hemolyzed while the first tube may be opaque or clear. If opaque it means that complement was entirely fixed in the first step of the reaction between antigen and syphilitic amboceptor which means a positive reaction.

If clear or hemolyzed it means syphilitic anti-body is not present in the suspected serum, or a negative result.

### A DISTINCTIVE PIECE OF LITERATURE.

"Here is something different." This is apt to be the first thought of the physician upon breaking the wrapper of Parke, Davis & Co.'s new brochure on bacterial vaccines and tuberculins. And the external appearance of the book is in no wise misleading. The "difference" applies to the printed page as well as to the handsome cover in artistically blended browns and gold. The brochure contains forty-eight pages in addition to the cover and thirteen full-page engravings in colors.

The work is divided into three parts or sections. Some of the subjects considered in the first section are: "What is the Difference Between Bacterial Vaccines (Bacterias) Serums and Toxins?" "How are Bacterial Vaccines Prepared?" "Therapeutic Action of Bacterial Vaccines"; "When Should Serums be Used, and When Bacterial Vaccines?" The second section treats of the origin and nature of the bacterins, the relative merits of "stock" and "autogenous" vaccines, the opsonic index, and the best method of using the bacterins, together with a description of each vaccine, including references to preparation, therapeutics and dose. The third section is devoted to a consideration of the tuberculins, with dilution and dose tables, descriptions and illustrations of the various diagnostic tests, etc.

Briefly stated, the booklet is a concise review of the essential facts relating to bacterial-vaccine therapy, containing precisely what the seeker after this kind of information wants. It is not padded with clinical reports—in fact, it contains none. We understand that Parke, Davis & Co. will be pleased to send a copy of this unique and valuable brochure to any physician requesting it. Address them at their home offices, Detroit, Mich., specifying the "new booklet on bacterial vaccines," and mention this Journal.

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## THE JOURNAL

## OF THE ALUMNI ASSOCIATION

OF THE

## COLLEGE OF PHYSICIANS AND SURGEONS, BALTIMORE.

### THE NATIONAL DEPARTMENT OF HEALTH.

This is an opportune time to call the attention of the Alumni to the fact that another effort is being made to secure a National Department of Health, which would take over the work of the departments doing hygienic work, now scattered through the various services of the government, chief of which are the Marine Hospital and Public Health Service in the Treasury Department and the Division of Chemistry in the Agricultural Department. It seems a very remarkable fact that the health of man has not received more attention in this country than it has, and with the great object lessons of what can be accomplished in sanitation, as exemplified in the work of Colonel Gorgas in Havana and later in Panama, it seems to be one of the wonderful things of the age that we have so long neglected this important subject. With the pollution of the great lakes and various rivers with typhoid and with amebæ, and possibly with tape worm, and with the recognition and spread of pellegra and the hook worm disease, state lines cannot always be carefully regarded, and the proper place for the care of such interstate sanitary questions lies in the United States government. This sort of supervision has been given animals for many years. A very good example of how the Agricultural Department acts in the face of epidemic threatening the property of the farmer is shown in the handling of the epidemic of foot and mouth disease, which occurred not long since in one of the northern states. The same prompt action and energetic, scientific dealing with human disease would bring just as great rewards and would be just as much saving in dollars and cents as when applied to animals. The chief opponents of a Department of Health are manufacturers and vendors of adulterated foods and drugs, aided by various sects of so-called medicine and hygiene, such as Christian scientists, the osteopath and the cheiropractic, and similar but not so widely disseminated beliefs. This would be a very good time for each alumnus to communicate with his senator or congressman and ask his support in the establishment of a National Department of Health.

### MERCY HOSPITAL LINEN SHOWER.

The Woman's Auxiliary of Mercy Hospital will hold a linen shower in January for the benefit of the hospital. Donations of sheets (72 x 99), pillow cases (45 x 36), doilies, towels, table covers, bureau scarfs, table napkins, etc., will be most gratefully received.

Any one desiring to help the hospital can do so by sending one or more of the above-mentioned articles to Mercy Hospital, Calvert and Saratoga Streets, Baltimore.

### ALUMNI NEWS.

A most interesting volume has been presented. It is the class history of the class of '79. This volume is the result of much painstaking work by Dr. Geo. H. P. Cole, of Roanoke, Va., a member of '79.

Dr. Cole practiced medicine until 1886, when he decided to give up the practice of medicine and engage in the banking business. In this he has been most successful. In 1887 he established the banking business of Geo. H. P. Cole, in Hendersonville; later on the Bank of Waynesville, N. C. In 1903 he organized the Peoples National Bank of Roanoke, Va., to which city he had removed after selling his interests in the Carolina banks.

In 1904 he resigned the presidency of the Peoples Bank and organized the American Savings Bank in Roanoke. This bank was sold by him to a number of capitalists in 1910, and since then the doctor organized the American Trust Company, of which he is president, and has associated with him his son Mr. John M. Cole. Dr. Cole has travelled extensively not only visiting almost all the states and territories of our

own country, but has visited Egypt, the Holy Land and Cuba. While lack of space does not permit us to quote from this interesting volume, we may interest the alumni by bringing Dr. Cole's foreword to their notice.

"In undertaking the work of compiling the sketches in this volume, I have been actuated by two motives—one to perpetuate as far as possible our pleasant associations, and the other to provide each of us with information concerning those classmates who are living and those who are dead. In reading this book I know that all of us will find in it some things to make us sad, and some to make us glad. Remembering the ambitious young doctors who left the College of Physicians and Surgeons in 1879, with their lives stretching before them with all sorts of possibilities, we shall grieve when we learn of those whose careers are ended, of the tragedies that marked the fate of a few, and of the dimness and brevity of the days allotted to some of them. Beyond the dark shadows that rest between them and us, we cannot penetrate, but we can let their memories live, we can cherish pleasant, kind and honorable thoughts of them, and give to them the tribute of our love and esteem. And we shall entertain the hope that in the ultimate plans of Providence we shall come to a time when classmates can greet each other again and clasp hands in happy recognition. Those of us whom God is blessing with abundant years and a share of prosperity will, I know, read these sketches with deepest interest, and in each of them find something to touch our hearts, to awaken us to a livelier care for the friends of other days, and to teach us that old associations should not be forgotten."

Dr. Thomas W. Kay, '79, prefaces the volume by a class history of '79. Dr. Kay graduated at the head of his class and was appointed in charge of the Womans Hospital under Professor Erich. In 1880 he located in Columbia, Pa., but left there to accept an appointment to the chair of materia medica and therapeutics of the Syrian Protestant College at Beyrout, Syria. He subsequently visited many of the European hospitals and spent considerable time under Pozzi of Paris. Dr. Kay finally located in Scranton, Pa., where he became successful from the first and is now enjoying a large and lucrative practice. Dr. Kay tells of the hard work and grind the men did in '79, and how on their very occasional nights off they saw from the peanut gallery, Booth, Jefferson, Mary Anderson and

Minnie Madden. He recalls the Saturday night collations of apples, taffy and peanuts.

A sad note enters his review when he records the death of Professor Brown. Fifty per cent of the class of '79 have passed away; five members died since their class reunion several years ago.

This volume is almost unique, the only other instance of a similar collection of sketches is that made by Dr. Harry Friedenwald of the class of '86, which was presented to the Alumni Association upon the 25th anniversary of '86.

Dr. Cole has published the history of '79 and each member of the class has received a copy of the book.

### CLASS REUNIONS.

As regards the reunions of classes '91 and '96, so little interest has been manifested in reply to our several notices that we do not feel justified in preparing a program for the meetings.

It is not fair to the small number of men who are interested to encourage them to come here at a considerable expense and sacrifice to meet only a corporal's guard. It requires a definite assurance of at least half of the class, for from past experience we know that only about 50 per cent of those who promise to attend can be actually expected to attend.

It is not that the alumni lose their interest, but the practice of medicine is such that many accidents occur which at the last moment cause the practitioner to change his plans.

## A LETTER TO THE CLASS OF 1875.

Dear Doctor Brack.—I am intensely interested in having a class reunion of the Graduating Class of 1875, the second Graduating Class of our Alma Mater (The College of Physicians and Surgeons), to take place about the time of our annual commencement of the college for 1912, in June, antedating the annual meeting of the American Medical Association.

I have made every effort to locate the various members thereof, with the following result. Those whom we have been able to locate, are as follows:

Albaugh, Eugene R. Bellville, Frank. Crow, A. W. Blake, John D. Giesler, D. A. Hyson, J. Miller.

Keller, Luther H.

Latimer, J. W. Micheau, Ellis. Newbill, C. F. Pierce, Franklin. Person, J. E. Saulsbury, Theodore. Stafford, C. E.

Vance, C. S. Wiley, Z. K. Walling, Byron W. Young, C. H. O. Sauer, Francis A. Wylie, C. Chase.

Those whom we have not been able to locate are as follows, with the addresses that we have of them:

Anderson, R. A., Big Lick, N. C. Burgin, Perry, Athens, Ky. Carpenter, Alex. W., Towsontown, Md. Owings, D. Clark, Ellicott City, Md. Cabell, Wm. C., Callanda, Ky. Chamblee, M. C., Wakefield, N. C. Emmert, A. Clark, Union, Tenn. McCullough, J. F., Shanes, Md.

McClellan, E. L., Stone Point, N. C. Osmun, Chas. J., Wakesville, Va. Pratt, W. E., Waysville, Va. Rankin, M. E., Parkton, Md. Ransome, Alex. L., Baltimore, Md. Trice, Warrick M., Greenville, Va.

I take this method of trying through the ALUMNI JOURNAL of the college to locate those in the last named list, and respectfully request any of our Alumni who know the address of any of them, or should this article come to the hands of any of them, to kindly notify me of their present location, and I shall be glad to communicate with them in the hope of having them with us at that time.

Any assistance that you may be able to render me in this matter will be highly appreciated by,

Yours fraternally,

JNO. D. BLAKE, Class 1875.

## TRI-STATE CHAPTER.

The Tri-State Chapter (New York, New Jersey and Connecticut) Alumni College of Physicians and Surgeons of Baltimore, held its first meeting for the season of 1911-12 on October 11, 1911. The meeting was at the home of the president, Dr. John W. E. Fitch, 355 W. 145th Street, New York, and was attended by a fair number of the alumni. The principal paper of the evening was by Dr. Alexius McGlannan, Associate Professor of Surgery and Surgical Pathology in the college. His paper was a review of the history, progress, prospects and ideals of the College of Physicians and Surgeons and Mercy Hospital. Following this Dr. J. G. Callison read a short paper on "The Vaccine Treatment of Typhoid Fever." This paper pointed out the response that may be expected on the part of the patient, reviewed briefly the work that has been done, and summarized the statistics of published cases.

### SECOND MEETING.

A meeting of the Tri-State Alumni (New York, New Jersey and Connecticut) of the College of Physicians and Surgeons, Baltimore, Md., was held at Actel Stetter's Restaurant, 844 Broad Street, Newark, N. J.

There was a large attendance. Meeting called to order by the president. After routine business Dr. H. B. Sheffield, of New York City, read first paper of the evening, on acute nephritis in children with special reference to the treatment of uremia. This paper was discussed by Drs. Knowles, Paganelli, Lanny, Sprague and Evans who dwelt particularly on the mental aberration of the subjects thus affected.

The second paper of the evening, by Dr. Wm. J. A. O'Hara, of Bridgeport, Conn., on borderland cases of appendicitis. Discussion by Drs. Cook, Sprague, Lanny, Knowles, Callison and Sheffield...

Third paper, by Dr. W. E. Fitch, of New York City, on the food and medicinal value of wines. Discussion by Drs. Evans, Paganelli, Sprague, Sheffield and Lanny.

A collation was served after the meeting. Next meeting will be held in Bridgeport, Conn.

## Dbituary.

Dr. George Calvert Stewart, '78, of Alexandria, Va., died in the Alexandria Hospital, August 16, aged 58.

Dr. Nelson W. Shugert, '85, died at his home in Tidioute, Pa., September 12, from heart disease, aged 51.

Dr. Alfred Dickson, '86, died at his home in Salamanca, N. Y., February 3, from rheumatic endocarditis, aged 52.

Dr. Jesse L. Stilwell, '05, of Freehold, N. J., died at the home of his uncle, near that place, December 17, from diabetes, aged 37.

Dr. Joseph M. Hollingsworth, '86, a member of the Medical Society of the State of North Carolina, died suddenly at his home in Mount Airy, April 12, aged 55.

Dr. James Marion Henry, '88, a member of the American Roentgen Ray Society, of Sioux City, Ia., died at Hot Springs, S. D., July 26, from cancer due to X-ray burns, aged 51.

Dr. John J. Cannan, '92, a member of the Medical Society of the State of Pennsylvania, attending physician to the Bradford Hospital, died at his home in that city September 23 from pneumonia, aged 43.

Dr. Alfred James Inloes, '69, a Confederate veteran, since 1893 a member and secretary of the board of education of Binghamton, N. Y., died in his home in that city, October 5, from cerebral hemorrhage, aged 71.

Dr. William Edwin Bonawitz, '89, of Millerstown, Pa., a member of the Medical Society of the State of Pennsylvania, died in Johns Hopkins Hospital, Baltimore, October 2, a few hours after an operation for the removal of gall-stones, aged 45.

Dr. James Gass, '91, a member of the American Medical Association and local surgeon of the Pennsylvania System at Sheffield, Pa., while driving his automobile over a grade crossing at Stoneham, October 22, was struck by a locomotive and instantly killed, aged 48.

Dr. Jefferson Dudley Poindexter, '86, a cadet at the United States Military Academy, West Point, N. Y., in 1883 and 1884, who entered the medical corps of the army in 1887, and was made captain in 1892, was retired with the rank of major in 1901 on account of disability in line of duty, and since his retirement has been a resident of Danville, Va., died at his home in that place, September 10, aged 45.

## Personal Motes.

Dr. Arnold Scheer, '03, of Eglon, W. Va., is a director in the local bank.

Dr. John W. Stewart, '80, is located at 163 Baldwin St., Elmira, N. Y.

Dr. George Merrick, '03, recently of Buffalo, N. Y., has left for the "wild and woolly West."

Dr. Voorhees has for several years been eye specialist at Elmira, N. Y., for the Pennsylvania Railroad.

Dr. C. F. Abbott, '03, has been local surgeon for the Pennsylvania Railroad for the past two years at Elmira, N. Y.

DR. FRED. MAYER, '03, formerly located in the Greenville section of Jersey City is now nicely located at St. Paul, Minn. He is also married.

DR. WILLIAM ALLAN was married to Miss Louisa Garnett Purcell, Thursday evening, December 28, in Richmond, Va. Dr. and Mrs. Allan will be at home, 504 East Avenue, Charlotte, N. C., after January 10.

Dr. Chas. F. Abbott, '03, has just retired as secretary of the Elmira Clinical Society, and has just been elected secretary of the Medical Society of the County of Chemung. He has recently been elected to the Fellowship of the Elmira Academy of Medicine.

DR. SHERMAN VOORHEES, '93, has just retired as president of the 6th District Branch of the Medical Society of the State of New York. He is now one of the two trustees of the Elmira Academy of Medicine, and one of the Censors of the Medical Society of the County of Chemung.

Dr. Melvin Coon is located at Laquin, Pa., where he has everything his own way being the only physician in the place. He is local surgeon for the Central Pennsylvania Lumber Company and for the Susquehanna & New York Railway. He is an '03 man, married and twice a "papa."

At the fourth annual meeting of the Railway Surgeons Association of the Pennsylvania Lines east of Pittsburgh, held in Atlantic City last September, there were a number of papers read by our alumni. These included one entitled "Some Cases of Interest to Me," by C. F. Abbott, '03, of Elmira, N. Y.; "The Treatment of Wounds outside of Hospitals," by A. W. Colcord, '93, of Clairton, Pa., and "The Reliability of the Statements of the Injured in Railway Accidents," by J. H. Vastine, '94, of Shamokin, Pa. Dr. A. C. Harrison, Professor of Anatomy,

read a paper entitled "Some Points Concerning Inguinal Hernia and its Radical Cure." Dr. Spencer M. Free, '80, of Dubois, Pa., is the president of the association and delivered the presidential address, and Dr. Colcord is the secretary.

## Correspondence.

THORPE, W. VA., Aug. 31, 1911.

C. E. BRACK, Treasurer.

Dear Doctor.—Enclosed find one dollar for subscription to Alumni Journal. I fell last winter and broke my hip and since have been unable to get on my horse, therefore am not doing any active work—but I still want the Journal. I have been appointed postmaster at my place and am looking after the duties of such.

I am, fraternally yours,

C. W. SPANGLER, '83.

South Manchester, Conn., Aug. 21, 1911.

Dear Dr. Brack.—Inclosed find check as per your statement. Will you kindly change my address from Keedysville, Md., to South Manchester, Conn. Best regards to you.

Sincerely,

RICHARD W. RICE, '09.

Moundsville, V. Va., August 16, 1911.

DEAR DR. BRACK, Baltimore, Md.

Dear Doctor.—Find enclosed check for three dollars, which please place to my credit for the Journal of the Alumni Association.

I enjoy the JOURNAL very much.

Am enjoying health at 200 avoirdupois, doing a good practice and think often of my associates of P. & S.

Yours truly,

W. P. Bonar, '06.

My Dear Brack.—Enclosed find check of \$2.00 for which please credit my account.

Am always glad to see the Journal.

Hoping you and yours are all well, with kindest regards to Mrs. Brack, I am

Yours, etc.,

H. R. McGAW, M. D.

### STAMFORD-IN-THE-CATSKILLS.

Dear Brack.—My dues for the Alumni Journal should not have been so long neglected. I herewith enclose check for \$3.00, amount due as per enclosed bill. I enjoy very much the papers and reports of cases appearing in the Journal, and letters from old friends and classmates are a great treat. Hope you and all the class of '95 enjoy peace, plenty and prosperity. Remember me to old friends who may be about Baltimore, and believe me,

Very sincerely yours,

JOHN E. SAFFORD.

### THE CHOICE OF AN ANTITOXIN.

No therapeutic agent which the physician uses to-day needs to be selected with greater care than the serums. These products must not only be individually specific, produced from specific germs or their toxins, but they must be pure—elaborated in the blood of perfectly healthy animals. The preparation of prophylactic and curative serums should never be intrusted to the inexperienced or to those who are hampered by lack of facilities. In choosing an antitoxin the practitioner should consider only serums of known reliability—products into which no element of conjecture enters. His own interests and those of his patient demand this.

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Assistant in Discases of Ohildren.

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Assistant in Discases of Ohildren.

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## THE JOURNAL

OF THE

ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS AND SURGEONS

BALTIMORE.

Vol. XV

No. 1

APRIL, 1912

PUBLISHED AT Greenmount Avenue & Oliver Street Baltimore, Md.





# Annual Commencement and Alumni Meeting

The Alumni meeting and banquet will be held May 31st at the Hotel Rennert.

The Commencement will be held on June 1st at the Lyceum Theater at 4 P. M.

The class of '75 will take part in these exercises. Dr. Blake's letter in this number will give details of '75 program. See p. viii.

P. & S. Headquarters for the A. M. A. meeting will be at Young's Hotel, Atlantic City

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(Table of Contents on Page 111.)
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# THE JOURNAL

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### BURNS AND THEIR TREATMENT.\*

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In looking over the later works of surgery, one is surprised at the meager treatment of the subject of "burns." Keen's Surgery, in five volumes, devotes only two pages to it in the article on burns, with additional short references in other parts of the work; less than five pages all told. Most text-books dismiss the subject with one-half to two pages. A careful search of the literature shows that very little has been written and not much work has been done on the pathology of burns, causes of shock or toxemia.

Visits paid by the writer to a number of large hospitals in various cities reveal the fact that not much attention is paid to this subject by the leading surgeons, this work being turned over to inexperienced internes. Ochsner says in Keen's Surgery that the "internes should be taught how to treat burns," which seems to me to be an admission: First, that this work is now being done by internes; second, that they have not, as a rule, been taught how.

It seems to me that the life of a badly burned patient is just as valuable as that of one with appendicitis, and he is deserving of the best surgical skill he can get. In one hospital there were 24 deaths in 88 cases, or 27 per cent.

I visited one hospital and asked to see the burned cases. The interne explained that they did not keep them in the general ward, as they smelled

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so badly that the other patients could not stand it. They had a special ward for them, and when I saw some of them dressed I did not wonder. Every burned surface was covered with pus and the smell was disgusting. Many writers speak of the absorption of pus from suppurating burns as a frequent cause of death.

We have long ago stopped talking about "laudable pus" in amputations and other operations, but seem to have retained it in burns. It is time the subject should receive the attention it deserves and that the results in the management of burns be brought up to the excellent ones obtained in other branches of surgery.

Among the causes of burns we have:

- 1. Steam.
- 2. Hot water.
- 3. Melted glass, wax, rubber, sugar, etc.
- 4. Molten metal.
- 5. Red-hot metal.
- 6. Gas and flame.
- 7. Burning wood, paper, clothing, etc.
- 8. Electricity.
- 9. X-ray.
- 10. Ultra-violet ray.
- 11. Chemicals.
  - (1) Acid, sulphuric, etc.
  - (2) Alkalies—common lye.
  - (3) Carbolic acid.
  - (4) Iodine.
  - (5) Croton oil, mustard, cantharides, etc.

Among the various varieties there is very little difference in symptoms, course, pathology and treatment. The molten metal burns are usually small in area, but of the third degree. The under-lying tissues are often devitalized especially around the feet, making a pale, deep, slow-healing ulcer. The same is true of many burns from electricity.

The effects of X-ray burns are only seen after several days or weeks and are very stubborn to treat.

Ultra-violet ray burns may not show any effects at first, but develop

symptoms in about six hours, sometimes being very painful, especially about the eye. They may be due to sunburn or powerful electric light.

As the skin is the principal organ concerned in burns, a few main points in its anatomy and physiology will refresh our memories:

Look at a diagrammatic representation of the epidermis. Note the horny layer on the surface and the germinal layer lying next to the papillæ of the true skin. This is bound to the papillary layer by the shape of the papillæ and by elastic fibers from the dermis passing up between the cells of the germinal layer. So firmly are they bound to the papillary layer that it is with great difficulty that they can be separated from the papillæ. Blistering never tears them away and the floor of a blister is never the papillary layer, as is stated by some writers. The line of cleavage is practically always above the germinal layer in the so-called prickle or mucous layer of the epidermis, lying next above the former. This is a wise provision of nature, for it is from these cells of the germinal layer that all other cells of the epidermis are reproduced. As the upper layers are worn away or destroyed, new cells are pushed upward from the germinal layer, becoming, in turn, cells of the mucous, granular and horny layers.

Should any portion of the true skin be entirely destroyed, it will be renewed from the edges by a multiplication of the cells of this same germinal layer.

The epidermis contains no blood vessels, but the mucous layer has lymph spaces between the cells, draining into the lymph spaces and channels of the dermis. There are a few non-medullated nerve fibers extending from the papillæ into the lymph spaces of the mucous layer.

Just beneath the germinal layer of the epidermis we have the papillary layer of the dermis with its capillaries, nerve endings, touch corpuscles and lymphatics. Its blood supply is from an intricate plexus of veins and arteries just beneath it, the sub-papillary, said to be without vasomotor nerves or muscular coats. Beneath the papillary layer is the reticular layer, containing the hair follicles, oil and sweat glands. It is supplied by a deeper plexus of larger blood vessels with muscular coats and vasomotor nerves.

Beneath the reticular layer is the subcutaneous connective tissue, less compact, with fat in its meshes. This subcutaneous fat has an important bearing on burns, since, being a good non-conductor of heat, it often pre-

vents involvement of the deeper tissues. Here also lie the large blood vessels and nerves and the Pacinian bodies, the supposed organ of the sense of pressure. In the true skin are muscle fibers and lymph ducts and spaces—all these structures held in place and bound together by white connective tissue and yellow elastic tissue.

Nowhere in the body are nerves more abundant than in the skin. Here we have nerves of motion to the muscles of the skin, nerves of pain, temperature and touch, forming an intricate plexus of non-medullated fibers, sending their branches upward into each papilla, and even to the mucous layer of the epidermis. Vasomotor nerves supply the coats of most blood vessels of the skin and trophic nerves are everywhere, controlling the nutrition of each part.

In the embryo, the epidermis is formed from the epiblast; the dermis comes from the mesoblast. The hair follicles, oil and sweat glands are formed from a downward pushing of the epidermis into the dermis. Now if we remember that epiblastic structure can be formed only from epiblast, that "like begets like," we can see how epidermis can never be formed from any other but epidermis, and never from the papillary layer, as has been so often taught. We can also see how, if the whole epidermis be destroyed, the germinal layer lining the hair follicles, oil and sweat glands may help us out in the formation of a new epidermis.

When we consider what a complex organ the skin really is; how delicately its parts are adjusted to the wants of the body; how extremely sensitive its nerve supply, slight stimuli bringing responses and causing reflex action in far-distant organs; when we consider the many uses of the skin—protection, excretion, expression and sensation in various forms; we can readily understand its great importance and the far-reaching results of its serious injury.

I have followed the usual classification of burns into those of first, second and third degree; but anatomically and clinically we will note two varieties of those of second degree.

In every burn there are two layers of tissue to be considered: First, the layer destroyed—the dead flesh. Second, the layer injured—the sick flesh.

#### BURNS OF FIRST DEGREE.

#### I. Pathology:

- 1. Destruction of cells of the horny layer.
- 2. Injury of the cells of the mucous layer with an excess of lymph in the lymph spaces. No blistering.
- 3. Congestion of the sub-papillary plexus with some destruction of the hemoglobin.
  - 4. Closing of the ducts of the sweat and oil glands.
  - 5. Slight edema of the underlying dermis.

#### II. Clinical Stages:

- 1. Stage of hyperemia and pain.
- 2. Stage of edema.
- 3. Stage of peeling and staining the skin.
- 4. Cells of the horny layer replaced by pushing upward of cells from the stratum lucidum.

#### BURNS OF SECOND DEGREE-FIRST VARIETY.

## I. Pathology:

- 1. Destruction of cells of the horny layer and of some cells of the mucous layer, but not of the germinal layer.
- 2. Great exudation of fluid composed of lymph, fibrin and broken-down cells in the lymph spaces of the mucous layer, forming blisters. Where the epidermis is thin there is but a single layer forming the roof of the blister, and when it is opened, it discharges its contents and collapses. Where the epidermis is thick, there may be separation in several layers with coagulated lymph in each space. The blister, when opened, does not discharge its contents nor collapse.
- 3. Injury of deeper cells of the epidermis in the "sick layer" with swelling of cells and proliferation of nuclei.
  - 4. Intense swelling and congestion of the papillary layer.
  - 5. Swelling of the connective tissue and elastic fibers in the true skin.
  - 6. Thrombosis in some superficial blood vessels.
  - 7. Blood changes in some other blood vessels:
    - (a) Chemical changes in fibrin.
    - (b) Destruction of white and red cells in large numbers.

- (c) Clamping of red cells, forming emboli, which are swept into the general blood stream.
- 8. Leucocytes poured out around the blood vessels.
- 9. Filling up of lymph spaces of the true skin with inflammatory exudate causing great edema. This exudate contains toxalbumins, which are intensely toxic to guinea pigs, rabbits and human beings. About the exact nature of these poisons, as well as the importance of their constitutional effects, there is much difference of opinion.\*
- 10. Destruction of non-medullated nerve fibers in the mucous layer and inflammatory changes in those of the true skin.
- 11. Inflammatory changes in the hair follicles, oil and sweat glands with arrested or perverted secretion.
- 12. Some epidermis may be shed without blister formation, even where the mucous layer is destroyed.

#### II. Clinical Stages:

- 1. Stage of blistering, edema, dermatitis, toxemia, pain, and (if extensive) chill and shock.
- 2. Discharge of absorption of contents of the blister with shedding of dead layers of epidermis.
  - 3. Subsidence of dermatitis in the true skin with absorption of exudate.
- 4. Reproduction of cells of the mucous layer from those of the germinal layer, which have formed the floor of the blister.

#### BURNS OF SECOND DEGREE—SECOND VARIETY.

# I. Pathology:

- 1. Destruction of all layers of the epidermis with the papillary layer of the dermis, often with a portion of the reticular layer, but not going deeper than the hair follicles, sweat and oil glands.
- 2. Usually deep blistering. The germinal and papillary layers often do not die until a few hours or even two or three days after the burn occurs.
  - 3. Destruction of the sub-papillary plexus of nerves.
- 4. Changes in the true skin as in Nos. 5, 6, 7, 8, 9 and 11 of "First Variety."
- \* For a full consideration of these poisons, with the various theories advanced by a number of investigators and for the bibliography, the reader is referred to the excellent paper of Ravogli, Cincinnati Lancet-Clinic, September 20, 1902.

## II. Clinical Stages:

1. Stage of blistering, edema, pain, dermatitis, cellulitis, with toxemia, embolism and, if extensive, chill and severe shock, followed by intense congestion of the kidneys, spleen, liver, stomach, intestines and meninges within a few hours. Many cases of severe burns die in this stage from shock, toxemia or congestion and emboli of vital organs. There may be also scanty or even suppressed urine. These same grave effects may follow extensive burns of the first variety.

2. Stage of absorption or discharge of blister contents with casting off exfoliated layers of epidermis; this stage occupying four to eight days. During this stage there is, in extensive burns, considerable fever.

3. Stage of natural skin-grafting. The remaining hair follicles, oil and sweat glands furnish germinal epithelium in minute bluish islands, scattered closely over the red granular surface. These enlarge until they coalesce. The other layers are now formed by upward pushing of cells from the germinal layer.

4. A certain amount of scar tissue is always formed in the healing of this variety in the under-lying "sick area." This sometimes causes much irritation of the contained nerves, and is, probably, the cause of the so-called "irritable burn" to be spoken of later. After healing the resulting scar is white and thin, but is not disfiguring.

## THIRD DEGREE BURNS.

## I. Pathology:

1. Cooking or charring of the whole skin through the reticular layer or deeper. It may involve only skin, or include any underlying structures, fascia, muscle, blood vessels or bone. The essential feature is total death of hair follicles, oil and sweat glands, with consequent destruction of all germinal epithelium.

2. The skin has a white, ivory yellow, brown or black appearance, according to time and intensity of the application of heat. It is hard and inelastic. There is no blistering.

3. There is usually a surrounding area of second degree burn shading off into a first degree burn.

4. Just beneath the "dead layer" is the "sick layer" with its inflammation, edema and blood changes. There is absence of the rapid formation of

toxins. Extract from burned muscles is non-toxic to rabbits, guinea pigs and man.

#### II. Clinical Stages:

- 1. Stage of destruction of tissue with underlying inflammation. If extensive, this degree of burn causes shock, probably non-toxic. During the early stage there is apt to be great pain from injury to nerves in the "sick layer," but not so great as in that of second degree burns, where the number of injured nerves is greater.
- 2. The general effects, toxemia, blood changes, embolism, congestion of vital organs, reflex effects from nerve injury, etc., with resultant chill and shock, are, probably, little different from those in extensive burns of the second degree, as few burns are purely third degree burns, but, if extensive, have also large areas of second degree burn.
- 3. Stage of sloughing. During this stage the second degree portion of the burn passes through its various stages and heals. The dead tissue shows at its edges a line of cleavage from the surrounding living skin. The slough is usually slow in coming away, owing to the direction of the connective tissue and elastic fibers, which bind it to the underlying structures. This stage lasts from one to three weeks. The process is more rapid in infected burns—a fact which has led some surgeons to poultice burns to this degree, a practice which cannot be too strongly condemned.

The depth of this burn will depend upon the degree of heat applied, the length of time applied, and several other factors about to be mentioned.

The danger of infection is always great owing to:

- (a) Presence of dead tissue.
- (b) The low resistance of adjacent sick tissue.
- (c) The open veins of lymph channels.
- (d) The adjoining skin which is difficult to sterilize.
- (e) The discharge of a large amount of serum, which forms an excellent culture medium.

There may be also severe hemorrhage as in any sloughing wound. The danger of this is greatly increased by infection, which breaks down the thrombi in the veins and arteries. The writer has never seen a serious hemorrhage in a clean burn. None occurred in the 2000 cases on which this paper is based. During this stage, if the burn is extensive, there will

be fever and other signs of toxemia from absorbed dead tissue. From this, death may occur.

- 4. Stage of granulation. The cavity left by the slough rapidly fills with new granulations. These have a tendency to rise above the surrounding skin.
- 5. Stage of epidermis covering. If skin grafting is not done, the new epidermis can be renewed only from the edges—a slow process often requiring months to cover the whole surface. Coincident with this stage is the
- 6. Stage of cicatrization. The granulations which fill the space left by the slough soon begin to contract—nature's effort to fill the gap. "The granulations are irregular, luxurious and abundant, and for this reason the scar resulting from a burn is irregular, uneven, inelastic, contracted, distorted, protuberant and disfiguring." (Ravogli.)

The line separating the dead tissue from the living is not only an irregular but also a movable one, that is, it descends deeper into the tissues during the first few hours or days after the burn. There is, just beneath the line, a zone of cells "Sick unto Death." How many of these will die, i. e., how deep the complete necrosis will extend, will depend on several factors. Among them are:

- (a) Character of heat applied. Molten metal burns keep extending for several days.
  - (b) Natural resistance of the tissues.
- (c) Vascularity of the part. Skin and muscle have a better resistance than tendon or ligament.
- (d) Condition of blood vessels—presence or absence of syphilis, arteriosclerosis, etc.
- (e) Condition of trophic nerves, as will be noted in the gradual sloughing burns of tabetics or patients having some other chronic nervous disorders.
- (f) Presence of infection. This will always cause the line to extend deeper, although it shortens the period of sloughing.

#### Prognosis.

When we are called to attend a severe burn we are liable to be asked questions like these:

1. Will the patient live?

- 2. Will there be scarring or deformity, and to what extent?
- 3. In what time will the patient recover?
- 4. Are his eyes burned? Will he be blind or deaf?
- 5. Has he inhaled the flame? Is he burned internally?

It has usually been taught that if one-third of the body is burned over, the patient will die. In my opinion it is not a question of mathematics, it is much more complex than that. I have seen one case live with one-half of the body surface burned, including large areas of third degree burns, while one of my cases, sent to a hospital, died with only a moderate burn of one leg.

If we were asked the prognosis in a case of acute lobar pneumonia, we would not base our opinion entirely on the amount of lung involved, but would take into consideration the age, sex, previous habits, and natural resistance of the patient; also the condition of his heart, kidneys, and other vital organs, his surroundings, facilities for nursing, etc. Let us apply the same common sense to the prognosis of a severe burn.

As to scarring, we can always predict it in third degree burns, although this can be minimized by early skin-grafting. But there are many severe burns which appear, at first, to be only of second degree, but gradually deepen in some areas until we have a burn of the third degree with resultant scarring.

As to the time of recovery, first degree burns get well in one to three days; those of the second degree, first variety, in seven to fourteen days; second variety, ten to twenty days. In third degree burns there is so much difference in size and depth that we must be guarded in our prognosis, six weeks to three months being a good estimate in the severe ones.

According to my observation the eyesight is seldom impaired; in fact, the cornea is not often burned, even in severe second or third degree burns of the face, including the eyelids.

Burns destroying portions of the outer ear rarely affect the patient's hearing.

As to inhaling flame, there is much erroneous opinion extant. In my series of cases, though a large number have had serious burns about the face, lips and nose from flame, burning gas or explosions, not one has been burned inside the mouth, throat or upper air passages. There was no case

of edema of the glottis. I am convinced that these are extremely rare accidents. It is also to be noted that severe burns about the lungs or abdomen do not directly injure the viscera when the dead layer reaches no deeper than the muscles.

There has been much discussion about the cause of shock in burns. Some claim it to be mainly psychic. Others, as Crile, claim it to be due to nerve injury, while many investigators, notably among the Germans, ascribe it to the rapid and intense toxemia. Each man brings forth good experimental evidence for his claim. In my opinion it is due to several factors, the most important being the following in the order named:

- 1. Psychic effect of a severe accident with added excitement from surrounding friends and bystanders.
  - 2. Severe sudden pain.
- 3. Rapid toxemia from absorbed poisons in the sick area, partly from hemolysins and partly from chemically changed lymph in the lymph spaces.
- 4. Reflex nerve phenomena from injury in the burned are of: (a) nerves of pain; (b) nerves of temperature; (c) vasomotor nerves.
- 5. Rapid congestion and embolism of vital organs. Autopsies on cases of death, apparently from shock in burns, even a few hours after the accident, show intense congestion of meninges, kidneys, lungs, stomach and intestines, with emboli of clumps of red blood corpuscles throughout these organs. (Ravogli.)

Ulceration of the duodenum, stomach and intestines following burns is probably due to embolism. There were no gastric or intestinal ulcers in my series. There were, in 2000 cases, eleven deaths, all but one during the period of shock.

Among the symptoms of burns we find:

- 1. Pain.
- 2. Shock.
- 3. Chill.
- 4. Nausea and vomiting.
- 5. Delirium.
- 6. High toxic temperature.
- 7. Scarlatiniform rash (occasionally).
- 8. Suppression of urine.
- 9. Albumin or blood in the urine.

10. Septic temperature if infected.

The causes of death are:

- 1. Shock, if within a few hours.
- 2. Toxemia, if between one and four days, from:
  - (a) Absorbed toxalbumins.
  - (b) Hemolysis.
  - (c) Arrested secretion.
- 3. Congestion of vital organs.
- 4. Embolism of lungs (Estes), brain, kidneys or other vital organs.
- 5. Toxemia from slough in one or two weeks.
- 6. Toxemia from infection of burn.
- 7. Suppression of urine (early).
- 8. Ulcer of duodenum, stomach or intestines.
- 9. Exhaustion from long suffering, suppuration, etc.
- 10. Hemorrhage from sloughing of a large blood vessel.

The question of shock, toxemia and emboli and the constitutional effects of burns are intensely interesting ones, but this paper concerns itself mainly with the treatment of burns. I would refer those who wish to pursue the subject further, to the works of Wainwright, of Scranton; Crile, of Cleveland; Burkhardt, Pfeiffer, Ravogli, and a number of others mentioned in Ravogli's article.

#### TREATMENT.

Looking over the literature of burns one finds almost as many varieties of treatment as there are writers. Some of the most popular are:

- 1. The Sneve Method.—Exposing the burn to the air and allowing it to dry as rapidly as possible, covering with wire gauze and other gauze to protect it. Some use a blast of hot air to hasten the drying. This method has given some excellent results and is growing in favor. Among those using it are Martin, Crile, Murphy and Urmson. It would seem to me difficult to employ it outside of a hospital.
- 2. The Continuous Bath of Hebra, for extensive burns.—The patient is suspended on a sheet in a tub of warm water, which is changed often enough to keep it clean. This is also popular in many large hospitals and is an excellent method in this class of cases (Ravogli, White, Murphy, Finney, who makes the bath alkaline, and Fancher).

- 3. Dusting Powders.—(1) Bismuth subnitrate (Ransohoff); (2) oxide of zinc (Corwin, of Hospital of C. F. & I. Co., Pueblo, Colorado); (3) stearate of zinc (White, of University of Pennsylvania; Sherman, Pittsburgh, Pa.); (4) aristol.
- 4. Dry Gauze.—(1) Plain sterile (White, Roberts); (2) aristol gauze; (3) iodoform gauze (used in hospitals in Germany); (4) carbolized gauze (White).
- 5. Ointments.—(1) Boric acid (Richardson, of Boston, 2 per cent; Finney, of Baltimore, 5 per cent; Brewer, of New York); (2) acetanilid, 1 per cent (Wible, of Homestead); (3) carbolized vaseline; (4) ichthyol and Peru balsam (Estes); (5) resin cerate (Lathrop, of Pennsylvania State Hospital); (6) acacia, white lead and linseed oil (Biddle, of Pennsylvania State Hospital); (7) equal parts of boric acid and zinc oxide powdered on burn; then covered with vaseline spread on gauze wrung from warm creolin solution (Estes, of South Bethlehem, Penna.).
- 6. Wet Dressings.—(1) Picric acid, used in solution strengths from 1 to 1 per cent—the most popular method. Gauze is applied wet with the solution and wet again from time to time. Among a large number of surgeons I note its use by Rodman, of Medico-Chirurgical Hospital; Lathrop, of Pennsylvania State Hospital; Ochsner, of Chicago; Rixey, Surgeon-General, U. S. Navy, ½ per cent; Estes, 1 per cent; Martin, University of Pennsylvania; Urmson, New Castle, C. S. Co.; Swaving, Fancher, Journal A. M. A., July 2, 1910; Albert Ehrenfried, Journal A. M. A., February 11, 1911; (2) aluminum acetate, 4 per cent (Ravogli); (3) normal salt solution (W. W. Keen); (4) sodium bicarbonate, 1 per cent (Estes, Brewer); (5) carbolic acid (1:500, Brewer; 1:200, Ravogli); (6) borax, 2 per cent (Estes, Young, of Glasgow, Scotland, International Clinics, Vol. 1, 1906) used to cover skin grafts; (7) creolin (Estes); (8) boric acid 3 parts, alcohol 1 part (Ochsner), used in sloughing burns of the third degree); (9) carron oil, mentioned only to condemn. The burn soon becomes infected and runs a septic course; (10) scarlet red (Ransohoff) for granulating surfaces.

For the methods of Estes, Lathrop, Biddle, Urmson, Swaving and Cannaday, see symposium on burns, *Therapeutic Gazette*, June 15, 1907.

One could pursue this list for another hour, if we give every new or freak method advocated by some one. I have selected only those which

have received the stamp of approval by those in authority as teachers, or those having long and large experience in the treatment of burns.

For the past ten years the writer has been using an ointment composed of:

Carbolic acid.

Thymol.

Menthol.

Camphor, of each 5 gr.

Ichthyol.

Balsam of Peru, of each 10 gr.

Zinc oxide.

Starch, of each 1½ drams.

Petrolatum to make one ounce.

Mix well.

It occurred to me that carbolic acid had some good properties in the treatment of burns. It is germicidal, a deodorizer and a local anesthetic, but it is irritating and poisonous. For some years I experimented to find a combination which would retain the three good qualities and remove the two bad ones. I believe this mixture has accomplished the result. These four crystalline substances—carbolic acid, thymol, menthol and camphor rubbed together produce a new product, which has neither the physical, chemical or therapeutic properties of either drug taken alone. It is a clear syrupy liquid. You may put your tongue into it and experience only a slight burning. Painted on the unbroken skin, it produces no redness, pain or gangrene, only a cooling effect followed by a slight local anesthetic. The balsam of Peru and ichthyol, advocated by Dr. Estes, are valuable aids in stimulating granulation and epidermis formation. The oxide of zinc and starch incorporated in a petrolatum base make of it a protective dressing of about the right consistency. After treating over 2000 burns with this ointment, I am convinced that it has the following advantages:

- 1. It is an efficient germicide and not only renders the surrounding skin sterile, but also keeps the discharges and burned surface free from germs and, therefore, free from pus. The only pus cases we get are:
  - (a) Those who take off their own dressings and so infect the burn.
- (b) Those who come after several hours or days with burns already infected.

- (c) Burns near the mouth, nose, or hair, or near the buttocks in babies.
- (d) Possibly some bad sloughing burns of the third degree, but these are treated as soon as a slough begins to form with continuous wet dressing of Ochsner's fluid, which prevents bad odor or pus.
- 2. It is a powerful local anesthetic and soon stops pain, especially in burns of the first or second degree. A badly burned baby, screaming with pain, will often go to sleep from the relief afforded before the bandages are all on.
- 3. It is a deodorizer. Our burns have no bad odor except badly sloughing third degree ones, and the odor is best controlled by the wet dressing.
- 4. It is non-poisonous. I have never seen a case where I thought absorption of the drugs produced any unpleasant symptoms.
  - 5. It is with some exceptions, to be mentioned later, non-irritant.
  - 6. It is easily and quickly applied and convenient to carry in the grip.
- 7. With this, dressings do not stick as they do with picric acid and many other applications. Men with slight burns can, with this dressing, work in comfort.
- 8. It is especially adapted to mill and office practice, where we do not have the perfect cleanliness of the hospital and where the open air (Sneve) dry method or the continuous bath is impracticable. It is the only method I have found that will keep a burn clean in the dirty homes of some of the foreigners working in the steel mills.
- 9. The recovery is much more rapid by this method, because: (1) The edema and inflammation of the skin soon subside; (2) there is no pus; (3) granulation and epidermis formation are stimulated.
  - 10. There is less scarring, because less destruction of tissue.

Some years ago I treated 30 cases with picric acid, and there was a general demand from these patients that we return to the ointment.

Let us suppose we are called to treat a severe burn of the second degree. We find the patient suffering agonizing pain with oncoming shock and a chill. We at once administer a hypodermic of  $\frac{1}{4}$  to  $\frac{1}{2}$  grain of morphia, 1-40 to 1-20 grain of strychnia, and 1-100 to 1-50 grain of atropin, to stop his pain and apprehension and combat the shock. We then see that the room is warm—80 to 85 degrees—clear it of unnecessary furniture and bystanders and order hot-water bottles, or hot bricks, gotten ready. The bed should also be prepared. If we have a nurse or assistant

at hand, we can order her to prepare the necessary things for a hypodermoclysis or a Murphy enema.

We must bear in mind that in every bad burn three things are more important than the local treatment:

- 1. Stop pain.
- 2. Combat shock.
- 3. Provide for dilution and elimination of the toxins, which at once are thrown into the blood.

Having gotten thus far with our work, we can proceed to do the local dressing. The clothing should be carefully cut away—never pulled off or dragged over the burned area. We must remember that a burn is, at first, sterile and we must try to keep it so. Unless we believe that it has become infected through dirty handling, dirty clothing dragged over it, or a dirty blanket laid on it, it is best not to wash the burn. Estes washes the surrounding skin with 5 per cent carbolic solution, protecting the burn with pledgets of wet gauze. With our burn ointment we have not found this necessary.

Pieces of gauze of convenient size are now spread thickly with the ointment and applied somewhat beyond the burned areas. Over this cotton and over all a bandage is placed. The patient is now put to bed, and if shock continues the normal salt solution is repeated every eight hours, giving plenty of water to drink. Nourishment for the first three days should be liquid on account of the intense congestion of the alimentary tract. There we may gradually feed according to conditions.

There should be the usual care of the bowels, skin, kidneys, etc., not forgetting, in our zeal over the local treatment, that we have on our hands a sick man with blood loaded with toxins, with meninges, lungs, stomach, kidneys and other organs congested and filled with emboli.

We re-dress our burns daily, gently wiping away the discharge of serum and broken-down cells, which is poisonous and irritating, with dry gauze or cotton. Blisters are opened and pieces of loose skin removed with sterile seissors or forceps, but all skin is left in place as long as possible to protect the underlying, new-forming skin.

Every dressing should be made with aseptic care, clean hands, clean gauze and clean instruments.

As the old epidermis is shed we have a red raw irritable surface, and we must reduce our ointment to one-half or even one-fourth strength. In an occasional case even this is too irritating and we change to oxide of zinc ointment or, better, to strips of gutta-percha tissue wet in normal salt solution. Over this are applied the gauze and one-fourth strength ointment, or zinc ointment, cotton and bandages. When the islands of epidermis have coalesced, we can change to aristol or any dusting powder.

Of course the greater number of burns are not so extensive, have no shock, and come to the office for daily dressing.

In burns of the third degree, the initial stage of shock, pain and toxemia is treated as in extensive burns of the second degree, and the ointment applied. As soon as the slough begins to form, if there is much odor, it is well to change to a continuous wet dressing. We prefer Ochsner's fluid with gauze, cotton and bandage. The patient or nurse is given a bottle of the fluid which is poured on every three hours without removing the bandage. The burn is re-dressed daily, and sloughing masses are removed when ready. We often see new epidermis forming along the edges before the slough has all come away from the deeper parts. The sloughing area is rapidly filled with red granulations, and if kept clean, the epidermis from the edges starts to cover it. During this period we usually apply the ointment daily one-half strength, using silver nitrate if granulations are too high at the edges. Where ulcers, following deep burns, are sluggish with a poor blood supply at the base, balsam of Peru or bovinine is used daily.

When the area is large in a third degree burn, skin should be grafted as soon as the slough is well away and the hole is filled with granulations. To wait until the granulating mass is old and high, we not only invite failure of the grafts to take, but we have a mass of scar tissue formed which will eventually contract with resulting deformity.

Murphy says: "In late grafting where a heavy mass of connective tissue forms beneath granulations, I advise that this be dissected out, down to the normal fascia, muscle, bone or other tissue beneath, before placing the graft."

We use mainly Reverdin or Thiersch grafts, covering with gutta-percha tissue strips and wet gauze dressing of normal salt or borax solution.

Young, of Glasgow, following the method of Wolf, Krause and Matas, has obtained some excellent results by grafting the whole skin with the

subcutaneous fat removed. He claims much more permanent results than with the other methods, greater elasticity and better appearances.

Much of the ugly scarring and deformity resulting from third degree burns is due to the neglect of skin grafting. It is often done too late or poorly done, and in many cases not done at all.

Reverdin grafting can be performed without an anesthetic and at the home of the patient. No apparatus is needed but some gutta-percha tissue, a pair of sharp scissors, mouse-toothed forceps, and some sterile salt solution. The wound surface and surrounding skin must be clean, the granulations firm and healthy, and there must be no bleeding. If near a joint, apply a splint to insure perfect rest, keep the parts constantly wet with normal salt solution. Leave the strips of gutta-percha tissue in place three days, then change to clean strips. Put on grafts, ½ inch apart, in rows, both ways, so that the strips may be crossed like basket work.

First degree burns are dressed once or twice with the ointment and discharged cured. Those of the face are covered with sterile vaseline or zincoxide ointment, or the burn ointment, and are left without bandages. They rapidly dry and heal without further attention.

Burns of the eye are dressed with Lippincott's ointment:

Bichloride of mercury, 1 gr.

Ammonium chloride, 1 gr.

Sterile vaseline, 5 ozs.

This can be put in the eye where the burn is on the eyeball or under the surface of the lid and gauze and bandage applied. These burns also do well with a wet dressing of boric acid solution. When the cornea is burned, atropin is used.

The writer desires to express his thanks to Dr. Wm. O'Neil Sherman, Chief Surgeon, Carnegie Steel Company, for the use of his personal correspondence on burns with many leading surgeons. Also to Dr. Geo. P. Mueller, of the University of Pennsylvania, and Prof. Wm. Simon, of the College of Physicians and Surgeons, of Baltimore, who have kindly aided him in preparing the pathology and chemistry of this subject.

In closing, there are one or two thoughts that I wish to leave with you:

1. No treatment of burns can be successful which does not consider the cleaning and sterilizing of the surrounding skin.

- 2. To have pus in any considerable number of one's burn cases is criminal. As careful attention to asepsis as in amputations will bring as clean results.
- 3. The choice of any of the good modern methods is not so important as how cleanly and carefully that method is carried out.

# THE ERADICATION OF PLAGUE FROM LARGE CITIES.\*

BY CHARLES W. VOGEL, M. D., REEDY ISLAND QUARANTINE, DEL.,

Passed Assistant Surgeon, United States Public Health and Marine Hospital Service.

On account of the prevalence of plague in epidemic form in Manchuria at the present time, it occurred to the writer that a short article anent the title of this paper might be of interest.

The bacteriological and clinical aspects of plague may be dismissed with a reference to the various text-books on medicine and bacteriology.

The eradication of plague from urban communities may be succinctly stated to be dependent upon two main factors, the destruction of the rat population and the rat proofing of all buildings of every description.

This statement is quite simple, but the practical application of the measures designed toward rat destruction is a very difficult matter at times. The experience of the Public Health and Marine Hospital Service in its anti-plague campaign in San Francisco in 1907 and 1908 demonstrated that a most potent factor in carrying out anti-plague measures is an aroused, intelligent, public opinion. If the public understands thoroughly what plague is and why the various measures are instituted, there will be much less obstruction to the work of the sanitary officer. On this account it is a very good plan to have the sanitary officers deliver popular lectures to the various civic bodies, as a very important part of the campaign. In these lectures the nature and history of plague should be dwelt upon, laying especial emphasis upon the intimate relation which rat plague bears to the prevalence of human plague. The co-operation of the city government in all of its departments is absolutely necessary, in order to arrive at results. Special ordinances must be passed through councils from time to time as

<sup>\*</sup>Reprinted from the New York Medical Journal for March 11, 1911. Copyright, 1911, by A. R. Elliott Publishing Company.

conditions may require. The measures directed toward the destruction or diminution of the rat population may be stated to be as follows, viz.: (1) Trapping of rats; (2) poisoning of rats; (3) deprivation of food supply of rats; (4) destruction of breeding places of rats; (5) rat proofing of dwellings, outhouses, yards, etc.; (6) rat proofing of stables, markets bakeries, etc.; (7) rat proofing of warehouses and docks; (8) rat proofing of all sewers.

The accomplishment of some of these measures must necessarily depend on the carrying out of different details under different conditions, but the principle of action remains always the same. It will be seen at a glance that the carrying into effect of some of these measures might offer almost insurmountable difficulties. The expenditure of time and money is necessary in order to properly rat proof buildings, etc., in a city, but this work can continue indefinitely as a settled policy after the more immediate work of fighting the plague epidemic has terminated.

So also the systematic destruction of rats should be prolonged indefinitely. Especially in seaports is the latter measure of the greatest importance. If a concerted effort could be made in all the principal seaport cities of the world toward a prolonged systematic destruction of rats, the danger of an epidemic of human plague in any of these cities would be reduced to a minimum. It was shown conclusively in the campaign in San Francisco that the cases of human plague decreased as the percentage of infected rats decreased, and the percentage of infected rats decreased as the number of rats trapped increased, showing that diminution of the rat population almost certainly causes a diminution in the percentage of infected rats. For trapping of rats two forms of trap were mostly used, the large cage trap and the snap trap.

The rat is a very cunning animal, and it was found necessary to change the style of trap used at a certain location from time to time, as also the method of placing the trap and the bait used. Cheese, bacon, and grain seemed to be the best bait. Fish heads and occasionally cabbage leaves also acted well. The cage trap has the advantage of, at times, enticing a large number of rats into one trap, as the rat is a very gregarious animal when in health. The cage trap will act particularly well if the first rat trapped happens to be a female, thereby luring the males to their doom. The snap trap of course can only trap one rat at a time, but it is very useful at times,

especially after the rats have become suspicious of the outer form of trap. The rat has quite a large amount of curiosity, and on this account he sometimes is caught in the snap trap while he is examining the same. Smoking of traps from time to time is very important, as after a large number of rats have been trapped, the trap retains the odor of the rodent, thereby warning other rats away.

Our experience in San Francisco caused us to rely on the mineral poisons almost exclusively, as we found that the so-called biological poisons were useless. Danyz virus, rattite, azoa, and a number of others of the biological poisons on the market were given a fair trial, but with very indifferent results. Danyz virus, if perfectly fresh, is probably active, but it would be impracticable to use it on a large scale, as it would require a large laboratory to produce the quantity required. Phosphorus and arsenic paste were used almost exclusively in the work in San Francisco. Any one of a number of phosphorus pastes on the market may be used, but great care must be exercised to guard against the possible occurrence of fire. For this reason arsenic paste was mostly used in San Francisco. The paste contained about 50 per cent white arsenic, with a base of corn meal and cheese made into a paste with some suitable menstruum. This was spread on cubes of bread and placed near rat holes and in rat runs.

Of course the estimation of the number of rats killed by poison is always more or less of a guess. In trapping one knows exactly how many rats are being caught, but then poisoning surely destroys a goodly number. So that it should always be employed in conjunction with the other measures of deratization.

The destruction of rat breeding places is very important. All piles of lumber, brick, or any similar material should be so placed that at least two feet of space remains between the lower surface of the pile and the ground. It should also have no interstices in the mass to offer hiding places for rats. All wooden areaways, boarded back yards, or boarded floors of basements should be torn up and replaced by concrete. In many instances in San Francisco nests containing litters of a half dozen or more of young rats were found in this way. So that we destroy the vermin in the easiest manner possible in this way and preclude the possibility of many new sources of increase in the rat population.

The deprivation of the food supply of the rat will depend almost solely

on the efficiency with which street cleaning, garbage collection and disposal, and general sanitary supervision of vacant lots is conducted by the constituted authorities. All garbage receptacles should be made of metal with tight fitting metal covers and kept covered at all times. This should be rigidly enforced by stringent ordinances. The garbage should be removed frequently and disposed of by incineration. Garbage dumping grounds in the outskirts of the city are a relic of the past and should be eliminated as rapidly as possible. These dumping grounds furnish an ideal rat harbor and very largely nullify the work of deratization that may be going forward in the city proper. Strict regulations should be enforced with regard to the prevention of refuse being allowed to lie about in markets, bakeries, etc.

Rat proofing can best be carried out by making the basements of all new constructions of concrete, the floors and the walls to a height of one foot above the ground to be so constructed. All stables, markets, warehouses, etc., with wooden floors should have the same replaced by concrete. All docks should be built in such a manner that they are rat proof. The details of construction would have to be determined by the circumstances in each case.

At seaports all vessels from plague infected ports should be required to have rat guards or funnels on the hawsers at all times while moored to the wharf and to lay off from the wharf at night. The holds of such vessels should be treated with sulphur dioxide several times a year for the destruction of rats.

Now a word as to the danger from the rat flea and other varieties of fleas on the common domestic animals. To guard against possible danger from rat fleas on domestic animals, the fur of these animals should be frequently well treated with pyrethrum powder, when any fleas which may be present are stunned and they can then be collected from the fur and burned. It is the opinion of the writer that the rat flea is comparatively of little consequence provided the rat, its host, is vigorously exterminated. All flea nests should be thoroughly drenched with crude carbolic acid or kerosene.

Every case of human plague should be immediately isolated in a special plague hospital.

The measures discussed in this paper comprise, it is believed, all the measures which would ordinarily be instituted in a campaign of eradication of plague from a city.

WILLIAM S. GARDNER, M. D., EDITOR, 6 W. Preston Street.

JOHN RUHRÄH, M. D., Associate Editor 839 N. Eutaw Street.

CHAS. EMIL BRACK, M. D., Business Manager, 500 E. Twentieth St.

# THE JOURNAL

# OF THE ALUMNI ASSOCIATION

OF THE

# COLLEGE OF PHYSICIANS AND SURGEONS, BALTIMORE.

#### THE COMMENCEMENT.

The commencement exercises will be held this year at the Lyceum Theater, on Saturday, June 1, at 4 P. M.

The annual meeting and dinner of the Alumni Association will be held at the Rennert Hotel the evening before the commencement exercises, Friday, May 31, at half-past seven.

# THE ATLANTIC CITY MEETING.

We wish to call the attention of the Alumni to the fact that there will be a room reserved for their use at Young's Hotel, during the Atlantic City meeting of the American Medical Association. This room will be in charge of one of the Alumni and may be used for a meeting place, correspondence, and for arrangement of informal dinners or meetings, as in previous years. We trust that every one of the Alumni attending the meeting will take time to stop in and register, if nothing more.

# MISFORTUNES OF DR. MANSUY.

In the Austin flood, which occurred sometime ago, one of our recent graduates, Dr. E. A. Mansuy, '06, had the misfortune to figure very prominently. At the time of the flood he was operating in the Austin State Hospital on a case of appendicitis. In the sudden rush of waters which followed the breaking of the dam, his wife and nine-month-old baby were drowned; his house, horses, vehicle and all other possession were washed down in the flood. We all wish to extend our sincerest sympathy to him in his troubles, and the Journal makes the suggestion that a fund

should be started for his benefit, as was done in the Bellevue College for Dr. Page, who also lost everything he had in the same disaster. The contribution may be forwarded to Dr. Charles E. Brack, 500 E. 20th St., Baltimore.

#### THE EPIDEMIC OF SEPTIC SORE THROAT.

For several months there has been prevalent in Baltimore an epidemic of sore throat which has been accompanied by marked swelling of the cervical lymph nodes and by a considerable amount of constitutional disturbance. Epidemics of this disease have been noted in Europe from time to time; the first record of it in this country is that of an epidemic which occurred in Boston last spring. In the Boston epidemic most of the cases of the disease occurred in individuals over forty and children were almost exempt. In the Boston, and in most of the epidemics which occurred abroad, the spread of the disease has apparently been through the milk supply, although it seems highly probable that the disease may also be transmitted by direct contact. The disease has also been noted this winter in Chicago, and Davis and Rosenow have a short article on it in the Journal of the American Medical Association for March.

The cause of the disease is a curious organism which may be readily demonstrated in the smears from the throat, or from exudates, and it usually appears as a small diplococcus, often in short chains. In the cultures the organism has a tendency to form longer chains, and it seems to occupy a position between the streptococcus pyrogenes and the streptococcus mucosus. Clinically the disease is very striking; there is first involvement of the throat, with considerable redness, often the entire throat being a dusky red in color; in some instances there is a typical follicular tonsillitis, while in other cases there is a definite membrane, usually limited to the tonsil. This membrane is not as adherent as that seen in diphtheria but might readily be mistaken for it. There is considerable prostration and fever, and there may be swelling of the lymph nodes almost from the outset, but the usual history is that after two or three days there is a remission and then after a day or two more a recurrence of fever and other symptoms, with the appearance of marked swelling of the cervical lymph nodes, and the name bubonic sore throat has been suggested. The course of the disease is slow, it may last from

one to three weeks and there is an unusual tendency to complications, including cedema of the eyes, which is usually unilateral, involvement of the nose, otitis media, erysipelas, peritonitis and abscesses. Many cases have been attended with marked gastro-intestinal disturbance. There are other cases in which the child is taken very suddenly with very high temperature, 105° and 106° F., and this temperature may tend to persist in spite of the usual antipyretic measures. There are marked prostration and depression of circulation and respiration, and many of these cases died within the first three or four weeks of the disease.

As prophylactic measures two things can be suggested—first, the boiling of all milk used for food, and second, the isolation of the patients. The treatment of the disease is along general lines and the most successful measures are those which tend to support the strength of the patient and keep up the nutrition; fresh air in the sick room and careful nursing are also important. As a rule severe purges should not be used. Surgical interference is often necessary for involvement of the ear or for abscesses or for the peritonitis, but in most of the peritonitis cases toxemia is so great and the patient's condition so alarming that laparotomy offers but little hope of relief. The lymph nodes should not be incised unless there is definite pus formation and notwithstanding the fact that they reach an enormous size they practically always subside without suppuration. Cold applications may be made locally, or such sedatives as lead water properly diluted, or belladonna ointment may be used.

## DR. RAY'S ANNIVERSARY DINNER.

The following card of invitation was the forerunner of a very delightful dinner given by Dr. C. A. Ray, of Charleston, W. Va., on the occasion of the 25th anniversary of his graduation:

1887

C. P. S.

1912

#### DR. C. A. RAY

#### At Home

Friday, March Fifteenth, Nineteen Hundred and Twelve to the Alumni,
College of Physicians and Surgeons, Baltimore Maryland
Twelve Hundred and Ten Quarrier Street
Charleston, West Virginia

Luncheon at One P. M.

R. S. V. P.

The following account, written by Dr. A. A. Shawkey, will be read with a great deal of interest:

As we gathered in the reception hall a large placard "Friedenwald's Mydriatic" directed our attention to a sumptuous bowl of delicious punch. The Mydriatic appeared in the form of a quart of apple brandy, to be added to taste.

At one o'clock we were summoned to the dining room where we partook of many courses of most delicious food with plentiful supply of liquid refreshments interspersed. When at last we had done ample justice to the delectable viands we were treated to a flow of wit and refreshing reminiscences of the college days of all years from 1887 down to the present, and none of the present or past members of the faculty but came in for his mention and universally favorable comment.

It was a most refreshing and rejuvenating occasion and we all feel as though we had been back and renewed acquaintance with our friends of the faculty and adjunct faculty of old P. & S.

Those who were present are as follows and each responded most interestingly to the toasts as proposed by our host who filled most exceptionally the office of toastmaster:

Dr. C. A. Ray, '87, "The big medicine."

Dr. W. A. McMillan, '03, "The only hospital man. Why don't you employ male nurses?"

Dr. Ira P. Champe, '92, "The horse vs. the auto."

Dr. W. F. Shirkey, '93, "College days at P. & S. as seen by a professor."

Dr. B. S. Preston, '02," When the mine doctor comes to town."

Dr. D. G. Preston, '07, "Twins or triplets?"

Dr. O. L. Aultz, '91, "Why would you never vaccinate a lady on the arm?"

Dr. A. A. Shawkey, '00, "Our faculty."

Dr. W. J. Thomas, '92, "Student prayer."

Dr. I. C. Hicks, "The doctor in politics."

Dr. C. E. Copeland, '93, "If you had it to do over would you study medicine?"

Dr. J. S. Morris, '04, "What's the excuse for being a bachelor in Charleston?"

Dr. C. E. Park, '05, " Cog city doctors and the glad hand."

At 5 o'clock we drank to Dr. Ray, to the Faculty of P. & S. and to our

alma mater, and as we filed out of the dining hall we were greeted by the doctor's charming wife who bade us adieu and presented each with a beautiful button-hole bouquet as we departed after having enjoyed one of the most delightful occasions of our lives.

Over the center of the table was suspended a large placard lettered:
P. & S. Soothing Syrup.

 $\mathbf{R}$ 

Eat.

Drink.

Be merry. āā qs.

Effervescent grape juice, O. ii.

M.

Sig. 30 gtts. every 30 seconds for 30 days.

Hand-done place cards bearing the toast and suitably illustrated were a feature.

# Marriages.

Dr. Harold Longsdorf was married to Miss Maude Adelle Thearle, the daughter of Mr. and Mrs. Thearle, of Baltimore, on Friday, April 5, 1912.

Dr. CLAUDE VERNON GAUTIER was married to Miss Hilda Estelle Kanode, the daughter of Mr. and Mrs. Marshall Kanode, on Wednesday, December 27, 1911, at Huntington, W. Va.

Mr. Charles J. Halper, pleasantly remembered by everyone who ever knew him as Col. Charles J. of the late unpleasantness with Spain, was married to Miss Fannie Keppler, the daughter of Mr. and Mrs. Solomon Keppler, of New York City, on Sunday, February 25, 1912.

Dr. Anthony Rytina, of the surgical department of the College, was married to Miss Catherine Gier, the daughter of Mr. and Mrs. Frank C. Gier, of Washington, D. C., on Wednesday, January 24, 1912. Dr. and Mrs. Rytina are making their home at the Shirley in Baltimore.

# Dbituary.

Dr. Charles E. Moore, '83, of McKeesport, Pa., died in a hospital in Pittsburgh, March 23, aged 57.

Dr. Arthur M. Walkup, '81, a member of the Medical Society of Virginia, died at his home in Gala, January 31, from cerebral hemorrhage.

Dr. OSCAR REDD COLBERT, '85, a member of the Medical Society of Virginia, and a practitioner and dentist of Warrenton, died at his home, February 1, from epithelioma of the ear and jaw, aged 68.

Dr. James Fabius Beckwith, '81, of Plymouth, Pa., died in Mercy Hospital, Wilkes-Barre, January 23, from embolism, complicating an acute appendicitis and ventral hernia at the site of a former operation on the gall-bladder, aged 59.

DR. CALEB COLUMBUS CONWAY, '86, formerly a clergyman of the Methodist Episcopal Church, and for about twenty years a resident and school director of Whitely, Pa., died at his home in Garard Fort, March 16, aged 64.

Dr. Marley Milfred Lockwood, '96, a member of the Medical Society of the state of California, formerly a practitioner of Hallock, Minn., and coroner of Kittson County, died at his home in Colusa, April 2, from nephritis, aged 45.

Dr. OSCAR PORZER, '06, of Bloomfield, N. J., a veterinarian in the army during the Spanish-American War, died in the German Hospital, Newark, N. J., from malignant disease of the jaw due to the kick of a horse fourteen years before, aged 41.

Dr. Amos Burn Straight, '91, a member of the Medical Society of the state of New York, and one of the best-known practitioners of Western New York, formerly a clergyman of the Methodist Episcopal Church, died suddenly at his home in Hornell, January 9, from heart disease, aged 45.

Dr. Henry Sinclair Castleman, '82, a member of the West Virginia State Medical Association, who underwent operation in a Baltimore hospital several months ago and who had not regained his former health and strength, died suddenly at his office in Martinsburg, March 1, from heart disease, aged 53.

Dr. J. Newton Lewis, '92, was killed in an automobile accident on the night of April 6. Dr. Lewis and a party of friends were returning to his home when the driver lost control of his car and ran into a fence. As a result of the accident Dr. Lewis and one other member of the party were killed. Dr. Lewis was born in Jefferson County, W. Va., and at the time of his death was 45 years of age. He was educated at Washington Lee

University and subsequently studied medicine at the College. After he was graduated he located in Roanoke, Va., which he has since made his home. During his residence in Roanoke he was prominently identified with both the state and local medical societies, and for many years was the coroner of Roanoke and surgeon of the Norfolk and Western Railway. He is survived by a widow and a brother, Dr. G. D. Lewis, of Washington, D. C. Dr. Lewis was probably one of the best known of the alunmi and will be recalled by many as the coroner of Roanoke. He frequently attended the meetings of the Alumni Association and commencement exercises and was at one time president of the Alumni Association. He was one of the most popular men that ever studied in the College.

# Personal Motes.

Dr. M. M. RAPPARD, '92, of Middlebourne, W. Va., is president of the Tyler County Board of Health.

Dr. J. M. LYNCH, formerly of the surgical staff of the hospital, has opened an office in the Drhumor Building, in Asheville, N. C., and will limit his practice to surgery.

# Correspondence.

SALISBURY, N. C., Nov. 27, 1911.

Dear Dr. Brack.—Enclosed find \$1.00 to pay subscription to the Journal of the Alumni Association.

I read the Journal with much pleasure and it is always interesting when I see the names of the men of '79, '80, '81. Many of them have passed to the great beyond and will no more be seen until we meet on the other shore. So far as I know the class officers of '80 are all living. Haseltine was president, I was vice-president, Vedder was secretary and Luther, treasurer.

I have always done a large general practice and have the reputation of being a close collector. In my county, state and national society work I have been honored with many positions. For five years I was treasurer of my State Society, and last year was made president of that body. I am examiner for quite a number of insurance companies, and

have been made 1st lieutenant in the Medical Department of the Reserve Corps of the U. S. Army.

I believe in post-graduate work and every year spend quite a little while at some post-graduate school. It pays and pays well.

I would so much love to hear from the members of the class of '80.

Very truly yours,

C. M. VAN POOL.

ERIE, PA., December 23, 1911.

My Dear Doctor Brack.—Please find enclosed check for \$2.00 in payment for subscription to the "Alumni Journal."

I have recently returned from a trip abroad, the greater part of the present year spent in Vienna and London. The greater share of my time abroad was spent in the study of pediatrics, and Vienna is certainly the spot to secure the real stuff.

The opportunity to study clinical material in Vienna is most excellent, concentrated and unlimited. Much of the work can be secured in good English under Hamburger and his assistants, and the actual work on children in Lorenz' orthopedic clinic is unsurpassed anywhere. We do the congenital hips ourselves, apply the casts, and the hammer and chisel are frequently seen every day, not at a distance in the hands of some professor, but actually operated by the American student, directed by the clinical professors and assistants. I took a month's work in the Wertheim obstetrical wards in order to secure the benefits of teaching of premature infants and the first ten days of the infant's life.

In 13 lessons I was given the opportunity of examination of 120 abnormal women; did two versions, one craneatomy, one decapitation, several forceps and a close witness of three extra peritoneal caesarean sections.

Should you ever have inquiry as to where to go for the best post-graduate work never fail to direct them toward Vienna, the Mecca of the world for post-graduate work.

Please forward Journal to 20 East 8th Street, where I am located in the exclusive practice of pediatrics.

Yours for a pleasant holiday season,

I am yours fraternally,

O. N. CHAFFEE, '06.

CHARLESTON, W. VA., March 16, 1912.

DR. CHAS. E. BRACK, Baltimore, Md.

Dear Doctor.—I wish to thank you for your letter with interesting facts regarding the faculty, which materially added to the pleasure of the occasion of Dr. Ray's anniversary dinner. It was particularly nice to have a word first hand from one of our faculty friends.

I will enclose some facts of the affair which I assure you was one of the most enjoyable occasions in the experiences of all who were fortunate enough to be present. Arrange and use what you wish of it.

Very truly yours,

A. A. SHAWKEY.

HOPEWELL, N. J., January 8, 1912.

DR. C. E. BRACK.

 $\begin{array}{ccc} \textit{Dear Doctor.} \text{--} \text{Enclosed find check for Journal of 1911.} & \textbf{I} \text{ am getting} \\ \textbf{along finely here.} & \textbf{Yours,} \end{array}$ 

T. A. Pierson, '94.

RALSTON, PA., February 24, 1912.

DR. CHAS. E. BRACK, Baltimore, Md.

My Dear Doctor.—I notice in Alumni Journal the announcement of a re-union of the class of '97. I have the honor of being one of that flock, and no greater pleasure could be mine than to have the opportunity and privilege of being present on such an occasion, to shake hands with old student friends, from whom we have been separated for 15 long years.

Fraternally yours,

J. L. MANSUY, M. D., '97.

CONNELLSVILLE, PA., February 13, 1912.

CHAS. E. BRACK, M. D., Baltimore, Md.

Dear Doctor.—Please find herewith enclosed check for two dollars (\$2.00) payment for subscription to the Journal for 1911-12.

The JOURNAL is full of interest and my only objection is it don't come often enough.

Wishing you all a prosperous year, I remain,

Fraternally yours,

THOS. R. FRANCIS.

SAVANNAH, GA., February 8, 1912.

DR. CHARLES EMIL BRACK, Treasurer, Baltimore, Md.

My Dear Doctor.—Enclosed find my check for \$2.00 for subscription to the Journal, which kindly address to me at Savannah, Georgia, P. O. Box 815.

I moved from Brunswick to Savannah, Ga., in May, 1911, and am doing well here. In March, 1911, I was operated on for gangrenous appendicitis and had a fistula and also phlebitis in left thigh and leg as complications. Am thankful to say I am now in a normal condition once more.

With kind personal regards, and hoping to see you before many months pass, I am,

Very sincerely,

T. W. CAUSEY, '09.

#### A NEW THYROID PREPARATION.

To Dr. S. P. Beebe, Ph. D., Professor of Experimental Therapeutics in Cornell University Medical School, the profession is indebted for a new and valuable preparation of the active principle of the thyroid gland. It is a carefully standardized product, consisting of certain proteids of normal glands, extracted, purified, and adjusted to a content of 0.33 per cent of iodine. Its preparation has been entrusted to Messrs. Parke, Davis & Co., and the product is offered to the medical profession under the name of Thyroprotein (Beebe).

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# FRIDAY, MAY 31, 1912

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Attending Class and Alumni Dinner at Hotel Rennert, 7 P. M.

# SATURDAY, JUNE 1, 1912

Morning. Class Meeting at the College of Physicians and Surgeons.

4 P. M. Commencement Exercises (Albaugh's Theatre).

7 P. M. Re-union Dinner (Class '75), Hotel Rennert.

As so many changes have taken place since our class days at the old P, and S. I feel very sure that those who fail to come will regret it for all time if they are not with us.

I have been surprised, since undertaking to arrange for this Re-union, to find that a large number of those that mingled with us in 1875 have gone to their final resting place. I therefore feel that the opportunity which now presents itself, if not taken advantage of, will not pass our way again. I therefore hope that nothing short of an actual calamity will prevent every living member of the class being with us, as well as the spirit of those departed.

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# THE JOURNAL

OF THE

ALUMNI ASSOCIATION

OF THE

COLLEGE OF PHYSICIANS
AND SURGEONS

BALTIMORE.

Vol. XV

No. 2

JULY, 1912

PUBLISHED AT
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## THE JOURNAL

## OF THE ALUMNI ASSOCIATION

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## COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE.

THE OLD CITY HOSPITAL.\*
By DR. WILLIAM S. GARDNER, '85.

During the past three years of active service, you young ladies have become acquainted with the workings of a modern hospital. You are familiar with present-day operative technique. You know how to keep a clinical record and to interpret its more obvious indications. You have taken a course in the diet kitchen and learned the method of preparing special dishes that please the palate of the invalid or that are prescribed by the physician as an essential part of his treatment. You have learned many things about beds, and baths, and rubs, and positions, and packs that add much to the comfort of the patient, and are of positive value as therapeutic measures. With more or less success you have endeavored to learn the vagaries of numerous specialists who differed among themselves as to the indications for applications or the administration of hot water or warm water or cold water, or the position of the patient, and a host of other details. During these months of work and study you have been preparing for work in one of the oldest of professions; but a profession that has changed so radically within the past few years both in its theories, and its practices that there is very little more relation between the practice of the present-day nurse and the nurse of a generation ago, than there is between the surgeon of to-day and his very near relative the barber. It must be difficult for one reared in the atmosphere of the present-day hospital to get a clear conception of, or to definitely understand, the conditions that surrounded the hospital patients so short a time as twenty-five years ago. We were then still in the age of the medieval surgeon and his

<sup>\*</sup> An address delivered at the commencement exercises of the Mercy Hospital Training School for Nurses, May 28, 1912.

medieval methods. The age of the physician who had a tremendously long list of drugs and only two remedies. The nursing was on a par with the surgery. The hospital buildings and equipments were wretched. All these conditions made a hospital a place not where patients went for relief, but a place where they went because there was no other place for the homeless and helpless to go. As typical of the institutions of that day and the methods then employed I would like to have you glance back for a few minutes at the old City Hospital as it was during the year 1886-87 when Dr. Harry Friedenwald and I were internes, or as we were then styled, resident physicians. The hospital was then located in what is now the eastern half of the building occupied by the College of Physicians and Surgeons. Since then this building has been materially altered. It then consisted of two stories and a basement.

The house men of to-day think that they are sometimes overworked and that they really lead strenuous lives. We never thought anything about it. We were only on duty twenty-four hours each day. All we had to do was to look after all the ward patients, do all the dressings, give the anesthetics, assist at operations, attend to the surgical cases in the dispensary, attend to the accident cases day and night, in winter to fill up the idle time we had private quiz classes, and we were even known to get out for a whole half an hour at a time for air and out-door exercise.

Our room was in the northeast corner of the main floor of the building. It has not been materially altered, but the junior interne of to-day scorns it as uninhabitable. It was not only our bedroom, but our reception room for visitors, reporters, and policemen, and a loafing place for the house students and the faculty. Our first caller in the morning was usually Dr. Coskery, who, coming in to make his rounds, not infrequently found us still in bed. He was fond of telling us how the old emperor used to make his rounds before daylight with a candle in his hand. Dr. Coskery was professor of surgery and one of the cleverest, clearest teachers who have ever been in Baltimore; but if he were to come back to a modern operating room he would be only a little more familiar with the technique than would Ambroise Paré, that master of detail and prince of nurses, who for sixty years was surgeons to the kings of France in the sixteenth century.

The making of the regular hospital rounds consumed considerable time because we then did all the dressings in the ward, took all the temperatures that were taken and made an examination of all new patients. No clinical records were kept, but in special cases there were sometimes recorded for temporary reference the fluctuations of pulse and temperature. We did not make any of those beautiful charts with criss-crosses of black, and blue, and red, which require an interpreter to translate. We did not have to bother with sterile dressings, we knew nothing about them. We used oakum; and we did not have a fair maiden in blue, or a symphony in white, to bring the oakum. We either got it ourselves, or it was brought by a ward master who was usually a patient who had partially recovered from a bout with that ever faithful and constant filler of hospital wards, John Barleycorn. The bandages we used were rolled by hand by convalescent patients usually in the ward and were never sterilized.

The main or white male ward was where the present college library is. It was a little larger than the present room, had light from only one side and contained twenty-five old wooden beds. In those beds were all classes of cases; fractures, simple and compound, beside typhoid fever; pneumonia side by side with tuberculosis, etc. On the same floor and just in the corner fronting both on Calvert and Saratoga streets was a room thirteen by nineteen feet and known as the sailors' ward. The four small rooms on the north side of this floor and one on the south side were sometimes used for private male patients; but in winter were usually occupied by house students.

On the second floor the space that corresponded to the male ward below was divided by a low double partition with a hallway between the two portions. The front division, or the part fronting on Calvert Street, was used as the white female ward, and the space west of the partition was allotted to the colored male patients. The only light in this ward came over the partition or indirectly from a skylight over the hall. It was gloomy, ill-ventilated and depressing. The only cheerful thing about it was the disposition of its occupants. The corner room on the second floor was called the private white female ward and was of the same magnificent proportions as the sailors' ward, that is thirteen by nineteen feet.

The patients who occupied these beds were for the most part seriously ill; because if they were not, they certainly would not have come into the hospital, and once in the inducements to remain could not be said to be sufficient to permanently wean them from the desire to live elsewhere.

About noon one of us daily went down to the dispensary to look after the ambulant surgical cases. In the basement, which is now too small to house the present dispensary, was located the dispensary, the doctors' dining room, the sisters' dining room, the kitchen, the pantry, the store room, a reception room, and on the north side was a long hall leading to the Calvert Street door which was the grand entrance to the hospital.

Dr. Keirle was the physician in charge of the dispensary. He was then, so far as any one could tell, just the same age, and looked just the same as he does to-day. He had the same white hair and beard, the same kindly ways, the same merry twinkle in his eyes and he told many of the same jokes, and related many of the same stories of his friend Dr. Ned Fernandis and himself that he does to-day. You must not gather from this that Dr. Keirle has not progressed. Though in appearance and manner he has changed so little, his work, as physician in charge of the Pasteur Department, has made him one of the recognized leaders of preventive medicine in America.

While speaking of the dispensary "Old Mack" should not be overlooked. I never knew his full name. He was just "Old Mack." He had a broque that he had brought with him from the Emerald Isle; an appetite for whiskey which had been industriously cultivated in America; hands that always reminded one of Quilp; and a collection of curled and matted reddish gray whiskers, sufficiently abundant to have supplied half a dozen of the most ambitious populists. He lived in the dispensary. He ate somewhere in the depths of the basement. He slept on a bench, or on a bunk, in one of the dispensary boxes. He drank whenever he could raise the price; but he was always on the job. Day and night he was always ready to help in his crude way with anything that was to be done. Much of the time he was the only assistant we had when giving first aid to fractures, dislocations, gunshot wounds, opium poisoning and like serious cases.

At two o'clock we had dinner. The room was small and the floor waved on its mud foundations as we walked over it, but it was kept scrupulously clean and neat. There the Lime Kiln Club met daily. It was composed of the residents and house students. A record of the pranks of the members would fill a considerable volume. They were not content with an occasional practical joke, they kept up a continuous performance. They

educated each other, and they attempted to educate Ann, the ancient Hibernian maiden waitress (she was over 60), in the language of east Tennessee so that she would be familiar with the ways of the people when she would arrive there as the blushing bride of one of the gray-haired house students.

The only operating room was the old college amphitheater. It had a common wooden floor and was surrounded by a wooden railing. This railing was scarred in many places by the thoughtless students who whittled it because it was the most convenient thing to whittle or because they sought to be remembered at the seat of learning by carving their initials where all could see them. This same room was used for post mortems, anatomical demonstrations and medical clinics. No woman ever entered it except as a patient. Its lack of cleanliness easily can be imagined. It was far dirtier than the present lecture and post-mortem room is when at its worst. Its absolute unfitness for a place in which to do operations was complete. Few abdominal operations were attempted; for in those days the surgeons lived in fear of the Lord and the peritoneum; and in a majority the fear of the peritoneum was the greater. If an amputation was to be done the patient was given chloroform in the hall back of the amphitheater and brought into this room which was reeking with infection. There was no pre-operative preparation of the limb further than to take the clothes off it. No valuable soap and water were wasted upon it. No such fetich as bichloride, or permanganate of potassium, or iodine or any other antiseptic was applied to it. The surgeon came in clad in a rubber rain coat buttoned up the back. The coat having been in many previous operations was spotted with blood and pus, and carried enough infection on its surface to have killed a regiment. The assistants usually took off their coats and rolled up their shirt sleeves. This was done to save the clothes, not the patient. The surgeon took his instruments from an old plush-lined case. Their handles were of wood or hard rubber, but always rough so that the grasp on them would be firm; and incidently, the rough surfaces were never thoroughly cleaned. These instruments were never sterilized from the time they were made until the time they went into the junk pile. The limb was amputated with a manual dexterity which was the pride of the operator and a source of comment by his friends. The blood-vessels were ligated and the wound sewed up with silk which was sometimes infected only by the dirty hands of the assistant and the operator. Not infrequently it had been exposed to other contaminations. The dressing consisted of a perforated rag smeared with vaseline on which was piled a mass of oakum and the whole secured with a bandage. When this was completed the operator and assistants usually washed their hands; that is, after the operation, never before it. Do you wonder that one of the notes made after an amputation of this kind read, "the wound is suppurating nicely"? No one reading that note at the time smiled. It was in the days of "laudable pus," and wounds were expected to suppurate. Is it any wonder that the morbidity was close to 100 per cent and that the mortality after major operations was frightfully high?

We may not have known much about aseptic surgery, but we were not lacking in ability to practice Christian Science. I doubt somewhat that our methods would have met with the unqualified approval of a true apostle of Eddyism, but as an evidence of their efficiency I would give you the outline of one case. A young man living in one of the suburban villages had been ailing and unable to work for about a year. His mother brought him into the hospital for treatment.

An eminent professor of clinical medicine diagnosed his case as one of stenosis, or constriction, of the small intestine. He delivered a clinical lecture to 400 students on the case and demonstrated to them all the signs and explained all the symptoms of intestinal stenosis. Therefore this youth must have had intestinal stenosis. However, the hospital interne does not always believe everything his chief says; and one doubted the accuracy of this diagnosis. He armed himself with a small electric battery and went to the boy's bed. The current was applied by a wire brush electrode over the bare abdomen for a few minutes. This application of the Faradic current was supplemented by a few suggestions stated very positively. In less than five minutes that boy, who, for months, had not been able even to sit up, was dancing for joy about the ward. The cure was complete and as an evidence that it was permanent for months afterwards, the grateful mother sent flowers to the sisters at the hospital to express her appreciation of the wonderful cure that had been wrought on her son.

So marked a difference between the management of the medical cases then, and now, cannot be shown as in the management of surgical cases because the change has not been so great, and because the physician was not such an active, or at least not such an obvious disseminator of infection. An effort was made to keep diphtheria, scarlet fever, and small pox out of the hospital, but nothing was thought of putting a tubercular patient next to one with pneumonia. It was not only not suggested that tuberculosis was contagious, but just the opposite was affirmed. In fact the then professor of medicine made fun of the statement that consumption was caused by the bacillus tuberculosis. He insisted that the experiments on rabbits with the bacillus proved nothing because the rabbit was so susceptible to consumption that if his tail were pinched he would promptly develop the disease. No attempt was made to disinfect the excreta of typhoid fever patients. Baths were not used to reduce their temperature. Screen to keep the flies and mosquitoes from typhoid and malarial cases and so limit the spread of these diseases had not been heard of, and many other useful and necessary appliances with which you are familiar were conspicuous by their absence. Is it any wonder that the public regarded all hospitals as pest houses and avoided them as they would any sure route to the grave? And when we recall that, for generation after generation, the hospitals had been the most prolific foci of infection that menaced the communities in which they existed, we begin to understand that inbred fear of hospitals of which we still see so many manifestations. This deeply seated fear, which was amply justified at its inception by the conditions, is, to this day, one of the great obstacles to the usefulness of hospitals.

But even during our term as hospital residents, from the east a few faint streaks of light betokening the break of a better day were making their appearance. The demonstration of Pasteur and Tyndall that fermentation and suppuration were due to the presence of micro-organisms, and the application of these discoveries to surgery by Lister, were just beinning to make an impression in this city. Few realized that a revolution in surgery was at hand. Already the obstetrician had begun to wash and carbolize his hands before examining a patient. He had not learned to wash the patient. Some of them have not learned it yet.

Dr. Erich, then professor of gynecology, first introduced the carbolic acid spray at the old City Hospital. The acid was sprayed over the field of operation by a jet of steam from a small copper boiler heated by an

alcohol flame. The result can be easily imagined. When long continued the hands of the operator and assistants were benumbed and if the patient escaped the dangers of infection was more lucky still if she escaped carbolic acid poisoning. Dr. Erich was also the first surgeon associated with the hospital who discarded chloroform and consistently used ether.

We used solutions of bichloride of mercury constantly in dressing suppurating wounds, but so far as I remember it was only during the latter part of our term and only for a few of the operators that it was used in preparing a patient for operation. I remember one case with great distinctness in which it was intended to be used. A concentrated alcoholic solution of bichloride was kept in a peculiar octagonal bottle. This was brought up and the solutions prepared and used. The next day I found out that the octagonal bottle did not contain the alcoholic solution of bichloride, but did hold Sister Veronica's holy water. The patient recovered promptly.

Even under the crude management that was given to wounds, occasionally one would unite by first intention. It was looked upon as something marvelous and shown to every visitor in the hospital. Nowadays one rarely hears of union by first intention because that is the way in which all wounds are expected to unite, and when they do not do so, a very definite cause must be located and the responsibility definitely fixed.

Perhaps you would like to hear something of the personnel of the staff of nurses who were in the hospital twenty-five years ago. Of operating room nurses we had none, we didn't know we needed them. The whole nursing staff consisted of two. Sister Mary Veronica, who had charge of the first floor, and Sister Mary Elizabeth, who looked after the second floor wards.

I must admit that time has made a little hazy my ideas of their ward work, but I am quite sure it would compare favorably with that done to-day. The nursing consisted largely in the giving out of medicines and the seeing that the patients had something to eat, but the house-keeping problems that go along with ward work had to be met and solved. When you bear in mind that each of these sisters had from twenty-five to thirty patients to care for, that there was no assistant; not even a probationer, that there was no night nurse, and that many emergency cases were ad-

mitted at all hours of the night and day, you can readily understand that theirs was a strenuous life.

Sister Mary Elizabeth was one of those bright, cheerful souls who knew something of life outside as well as inside the convent. She did her work with the co-operative spirit, with the pleasing manner, and with the conscientious devotion, which made it a delight to be associated with her.

Sister Mary Veronica was made of sterner stuff. She ruled her ward with an autocratic sway; but tempered that rule with the noblest intentions, and an ability to work wonders with the limited means at her command. She had not had the advantages of a training school; she had not studied anatomy, physiology, chemistry, and materia medica as you have done; but she had spent twenty-five years in practical ward work and she knew sick people. In cases of emergency, day and night, she was always on call, always cheerful, always patient and always efficient.

But you may ask what relation has all this to you as nurses and the nursing? With the changes that have taken place in surgery and medicine, the training school and the trained nurse have become an integral part of every modern hospital. Twenty-five years ago in the old City Hospital two sisters looked after fifty-five beds which were filled constantly with the very ill. To-day fifteen sisters and sixty-five nurses, a total of eighty nurses, are constantly engaged at Mercy Hospital, caring for 275 beds. The old ratio was one nurse to twenty-seven beds. The new ratio is one nurse to about three and a half beds. In other words the hospital beds have increased five fold, and the number of nurses has increased forty fold. The amount of work required has increased and is still increasing to such an extent that the cry heard from all large hospitals is "more nurses." So far as I can see the demands of the profession and the public will not, and cannot, be satisfied until that Utopian period arrives when each hospital patient will have two special nurses. A hospital may have the greatest surgeons and the most learned physicians in the land upon its staff; but without the nurses they would be like generals without an army; they could give orders but there would be no one to carry them out. There is not a hospital in this country that is not dependent very largely for its usefulness upon the efficiency of its nurses. With the greater refinement of detail in hospital work it has become necessary to specialize in nursing. The effort now is, not to get fairly good results, almost anyone can do that, but to approach as near as possible to perfection.

And the value of specializing in certain lines of nursing to bring about the desired result, has not been sufficiently emphasized or appreciated. Too frequently it is taken for granted that a trained nurse can do anything that comes within the whole curriculum of nursing and do it as well as any other nurse. Practically all nurses and some doctors know that this is not the case. Many nurses who do excellent work with medical cases are rank failures in the operating room and the reverse is occasionally true. It is of the greatest importance that these differences should be recognized by the public and especially by those in authority in hospitals. The selection of the proper nurse to fill a certain position adds tremendously to the ease and efficiency of the work. There is no place where this stands out more clearly than in the operating room. I take this as an example because I consider it the most important and the most difficult place to fill of any position in a modern hospital. The nurse in charge must be a woman of intelligence and absolute reliability. She must be familiar with every detail of operating room technique from the preparation of patients to the preparation of absorbable suture material. She must be familiar with all the ordinary surgical operations in order to make the necessary preparation for them and to give intelligent assistance during the operation. must know the complications that are likely to occur and be prepared to meet them. She must be something of an autocrat and able to have her directions carried out by her assistants to the minutest detail. She must understand and have her assistants understand that in an operating room there is only one way to do a thing, and that is to do it right. With all this she must be progressive and never get to a place where she cannot learn new things. A nurse of this kind cannot be educated in a day. She can be obtained only by starting with one who has the proper inborn qualities, and educating her by a long, tedious course of theoretical study and practical work. It is hardly necessary to say that nurses of this quality are rare, and when a hospital acquires one she should be prized at her true worth and given her just deserts.

#### APPENDICITIS IN CHILDREN.\*

By DR. HERMAN B. SHEFFIELD, '95.

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Until recently the prevalence of appendicitis in early childhood was not taken very seriously by the profession at large, and hence, either because of its skepticism, or for want of understanding of the pathology of the disease, a great many cases of acute or chronic appendicitis were either overlooked, erroneously diagnosticated, or newly discovered as "food fever," "cyclical vomiting," and the like. Nowadays, the occurrence of appendicitis in children and even in sucklings is no longer doubted. On the contrary, in view of the frequency with which the vermiform process is found implicated in the course of severe infantile gastro-intestinal disease, and its tendency by its relatively greater length and width to favor lodgment of foreign bodies (such as fecal concretions, worms, etc., which act as sources of infection), there is ample reason for the belief that appendicitis is at least as common in children as in adults. As in the latter the severity varies from simple inflammation to fatal gangrene, depending of course upon the type and virulence of the causative bacteria and the promptness with which it is discovered and treated.

Pathologically the simplest form of appendicitis consists of a catarrhal inflammation of the appendix. Its mucosa and follicles are reddened and swollen, and their secretion more abundant than normal. The lymphatics of the walls and of the surrounding structures are congested. Gradually the submucous and serous layers become involved and the appendicular lumen narrowed. In mild cases the obstruction in the appendix subsides, allowing the escape of the mucous and bacterial contents and, with the exception of slight thickening and adhesions, rapid restitutio adintegrum takes place.

In more severe cases the obstruction continues, the appendix becomes more and more distended, the mucous secretion purulent, the muscular

<sup>\*</sup> Reprinted from *Pediatrics*, May, 1912. Read at the annual meeting of the Tri-State Chapter (Connecticut, New Jersey and New York) Alumni of P. & S. of Baltimore Md.

coat, owing to its effort to expel the appendicular contents, thicker, hypertrophied, while the mucous membrane, as a result of pressure from within the appendix, undergoes gradual atrophy and ulceration. Even in this stage of the disease spontaneous recovery by encapsulation and absorption of the abscess is still possible.

In the majority of instances, however, instead of being absorbed, the purulent content of the appendix gradually, or rapidly, increases in quantity, and finally perforates the over-distended, more or less ulcerated appendix. The escaping pus finds its way where there is least resistance, into the cecum, small intestine, rectum, urinary bladder, gall-bladder, diaphragm or into the free peritoneal cavity. The pus may also penetrate into the retroperitoneal cavity or externally, usually in the right iliac region.

Sometimes the inflammation is almost from the start so intense that perforation and gangrene of the appendix, and escape of its virulent contents into the peritoneal cavity occurs before a diagnosis can at all be arrived at. In these cases it is not rare to find also old inflammatory adhesions, indicating that the patient has once before gone through an attack of appendicitis (recurrent appendicitis), which probably was mild and had escaped attention.

The great variability in the course and termination of the aforementioned pathological processes can readily be explained primarily by the difference in the virulence of the causal bacteria, no single type of which having thus far proved to be the specific etiologic factor of appendicitis as a whole or of any of its forms. The bacteria found in the inflammatory products of the disease are principally streptococci, staphylococci, the bacterium coli, the pneumococcus, influenza bacillus, etc. It is not at all uncommon for appendicitis to develop in connection with pneumonia, influenza, gastro-enterocolitis, etc., thus tending to prove its infectious character. Prominent etiologic factors also are: Retention of fecal concretions, foreign bodies (pins, fish bones, cherry stones, or orange pits), intestinal worms, traumatism, exposure to cold and wet, etc. Male children (being more often exposed to the last-named causes) are more frequently attacked by appendicitis than female. Constipation and dyspepsia serve as predisposing causes.

Acute appendicitis may set in very suddenly or be preceded by premonitory signs consisting of frequently recurring attacks of dyspepsia, with colic and constipation. It is quite probable, however, that the dyspeptic symptoms are in reality the manifestations of recurrent catarrhal appendicitis of very mild type. Appendicitis once established, the little patient stops eating, is nauseated, vomits and cries because of pain in the abdomen. The latter is more or less rigid. The anorexia is usually complete, and, if the child is forced to eat, the food is sooner or later ejected. Infants may continue taking the bottle or breast, to quench the ever-present thirst. In very mild cases nausea may replace the vomiting, but the latter symptom is always present in moderately severe cases and is quite severe in grave appendicular involvement, especially when the peritoneum is implicated. Pain, spontaneous and on pressure, is invariably present during an attack, but it varies greatly in severity irrespective of the pathologic condition of the appendix. Sudden cessation of pain is supposed to signify mortification of the underlying structures, and, hence, looked upon as a bad omen. Young children are usually unable to localize the seat of the pain they are suffering from; little reliance, therefore, should be placed upon their localization. On the other hand, pressure pain can readily be elicited, and, as a rule, is most intense over the region of the appendix, which in children does not always correspond with "McBurney's point"—the appendix is often situated either higher up or lower down in the pelvis. Sometimes even infants indicate the presence of pressure pain by attempting unconsciously to ward off the examining hand, by placing their little hands over the most painful spot. Rigidity of the abdominal wall forms a pathognomonic sign of the disease and proves of great help in the diagnosis of appendicitis to one familiar with the peculiar sense of resistance of the abdominal wall to pressure. As a rule, the abdomen is distended, but it may also be contracted and as hard as a board. On gentle palpation the rigidity yields sufficiently to permit the detection of tumefaction—i. e., the underlying thickened appendix in catarrhal appendicitis, or the variously sized, hard or doughy, immovable mass, in appendicular abscess. In some cases the tumefaction may be seen to project beyond the normal level of the skin, or be felt in the rectum, a digital examination of which, therefore, should never be omitted. Appendicitis is ordinarily associated with complete constipation; the attack may, however, be ushered in by diarrhea, or,

rather, pseudo-diarrhea, since the stool is derived chiefly from the lower part of the colon, superinduced by the sudden irritation within and about the appendix. As the disease advances, in consequence of pressure by the growing tumefaction in the pelvis, there may be severe tenesmus (as well as strangury) with or without a bloody discharge—a symptom which is very apt to mask the diagnosis. The temperature is moderate, from 101° to 103° F. in catarrhal appendicitis, and as high as 105° F., in abscess formation. In favorable cases the pulse and respiration agree with the rise or fall of the fever. Low temperature with a high, feeble pulse is considered a bad omen, an indication of profound sepsis.

Diagnosis.—Cases presenting the aforementioned typical symptoms of appendicitis can be diagnosed as readily in the child as in the adult. In fact, owing to the thinness of the infantile abdominal wall, and the proportionately large size of the appendix, it is usually not difficult to palpate an inflamed appendix unless it be—as it sometimes happens—misplaced somewhere beyond the reach of palpation. On the other hand, there is often considerable difficulty to differentiate an appendicitis pursuing a very violent course with marked tympanites, shock and collapse, from a grave attack of acute gastro-enterocolitis, typhoid with perforation, intussusception, hernial strangulation and the like. Even in such cases careful analysis of the typical symptoms of the respective diseases rarely fails to lead to a correct diagnosis.

Course and Termination.—The severity or mildness of the onset of an attack of appendicitis bears no positive relation to the further course of the disease. After the inflammatory process has, so to say, localized itself, which occurs usually within the first twenty-four or forty-eight hours, in the majority of instances the physician is able to conclude what sort of a case he is dealing with. By that time he will find that in catarrhal appendicitis the vomiting has partially or entirely ceased, the pain diminished, the abdominal rigidity lessened, and the tumefaction become less palpable. The child is able more easily to move about in bed, to have a few hours of comfortable sleep, occasionally to expel flatus, and to express a desire for food. Uneventful recovery may now take place within ten days, i. e., as far as subjective signs are concerned. In the majority of cases some morbid anatomical changes remain in the appendix and adjacent structures, e. g., inflammatory adhesions, kinking, constriction of

the lumen, etc. The region of the appendix thus remains a *locus minoris* resistentiae for life, subject to recurrent attacks of inflammation and its sequelæ.

Sometimes after an apparently benign course of a few days duration, either without discernible cause or as a result of gross errors in diet, undue exercise, and the like, there is a sudden change for the worse. The symptoms spoken of to occur with the onset return, sometimes even in more pronounced form; the patient vomits, has chills, headache, severe pulling and throbbing pain in the abdomen. The temperature rises, the pulse increases in frequency and tension, respiration is quick but superficial (the patient is afraid to take a deep breath or to cough owing to an increase of the pain with the descent of the diaphragm); the child is restless and sleepless, lies principally on his back with his right leg flexed (attempt to extend it aggravates the pain) and cries with pain on being moved about. Palpation reveals a distinct oblong tumor, the distended appendix, which is very tender and gives rise to a gurgling sound on pressure. If the disease is not checked by operation the indurated mass enlarges, loses its circumscribed character, becomes more doughy in consistency, and dull on percussion, in short, presents unmistakable signs of a fluid content, an abscess. This clinical picture of suppurative appendicitis does not by any means follow only the catarrhal variety; on the contrary, quite often it is in full development within the first two or three days of the disease and, if the abscess is not promptly opened it bursts, often giving rise to general peritonitis and quick death. More rarely the accumulation of pus occurs very slowly and gradually and even remains in abeyance for a period of weeks or months, during which time the abscess becomes walled off from the general peritoneal cavity by inflammatory adhesions, and may finally be absorbed, or, with recurrent attacks of appendicitis, perforate the sac and wander in any of the neighboring structures, sooner or later leading to the grave symptoms previously spoken of.

In another group of cases—fulminating, gangrenous appendicitis—the symptoms are extremely alarming right from the beginning of the attack. In the midst of apparent good health, or preceded by slight malaise, vomiting, colic, prostration and collapse, following one another in rapid succession, and often without palpable local appendicular tumefaction, or any other signs pathognomonic of appendicitis, the typical picture of general

septic peritonitis is in its full sway—sometimes within twenty-four hours (usually after from three to five days) carrying the little victim to the grave. In such cases post-mortem examination reveals either pre-existing infection of the peritoneum, or sloughing of a gangreous appendix, involvement of adjoining blood vessels (thrombophlebitis) and general sepsis (pyemia).

In view of the uncertainty of the course of the disease, every case of appendicitis should sooner or later be operated upon. This opinion is in accord with that held by the best clinicians of this age. The profession is still divided, however, on the question of the time when operative procedures prove most propitious for the patient's uneventful recovery. In solving so difficult a problem, the physician must be guided: 1, by the condition of the patient, and 2, the progress of the disease.

- 1. The Condition of the Patient.—It certainly would be folly to operate on a child in moribund condition, or on one synchronously suffering from a systemic fatal disease per se, e. g., miliary tuberculosis, diabetes, grave heart or kidney disease, and the like. An operation should be deferred in infants under six months of age because of the lack of resistance of the patient, and in view of the fact that in very young infants spontaneous recovery (at least temporarily), by absorption of the pus, or rupture of the abscess in the rectum are by no means rare.
- 2. Progress of the Attack.—Mild catarrhal appendicitis, with the first attack, progressing favorably during the first four days, may be left alone until the quiescent stage, when the appendix should be removed. Severe or recurrent catarrhal appendicitis failing to improve after the fourth or fifth day, or, showing incipient symptoms of suppuration (increased leucocytosis), should be operated upon at once; or, if for some reasons an operation cannot be undertaken, treated medically for a week or ten days longer, until the abscess has become circumscribed and encapsulated, when an operation should be performed without further delay. The same rule applies also to all cases of slowly developing suppurative appendicitis, the physician being constantly on the guard, however, for sudden threatening symptoms of perforation—in the latter event demanding prompt surgical interference. Finally, an immediate operation is imperative in all cases of perforative and gangrenous appendicitis, procrastination being almost invariably fatal.

In advocating operative procedures I presuppose that a competent surgeon is within reach to perform the operation. Otherwise the patient will fare better under medicinal treatment, which though only palliative is nevertheless potent to tide over the acute symptoms-often to hold the patient alive long enough until the services of a competent surgeon can be enlisted. The discredit cast in various quarters upon the surgical success in appendicitis to a great extent is due to the fact that the statistics compiled to show the bad results of operative treatment of appendicitis embrace the work of the competent and incapable surgeons alike, failing to specify that the work of the incompetent is chiefly responsible for the high mortality. It is one thing for a surgeon skilfully to remove a purely inflamed appendix, and quite another to be able successfully to meet emergencies in badly complicated appendicular abscess or gangrene. The sooner, therefore, the attending physician will appreciate the fact that in the majority of the promptly treated cases the prognosis of appendicitis depends solely upon the skill of the surgeon, the quicker will the mortality from this affection dwindle down to insignificance.

When a patient is seen early, it is advisable to administer one dose of castor oil or calomel with bicarbonate of soda, and to wash out the stomach and intestine-to clean the alimentary canal of its contents. This should be followed by an occasional administration, in the form of suppositories, of very small doses of codeine or opium, to arrest peristalsis and to keep the child perfectly at rest and free from severe pain. No medication by mouth! During the acute stage of the disease, the constant application of ice is useful to relieve pain and arrest rapid progress of the inflammation. Thirst should be relieved by small quantities of water or tea, and as long as anorexia exists, no attempt at forced feeding should be tolerated. An occasional teaspoonful of milk, beef juice or broth, will prove sufficient to sustain life for days. Any indiscretion in the diet is hazardous. More liberal feeding may be practiced after subsidence of the acute symptoms, after repeated escape of flatus, or partly formed stool. Even then extreme caution is commended, limiting the dietary to slowly increasing quantities of milk, broths, albumin water; in older children, fresh soft-boiled eggs, milk toast, small portions of fine cereals, etc. For marked flatulence, atropine hypodermatically. Stimulation by means of strychnine and normal saline solution, both subcutaneously, should be resorted to in accordance with indications. As the patient improves, medication in the form of stomachics, intestinal antiseptics and laxatives may be administered by mouth, and the supply of nutritious food increased, so as to heighten the patient's vitality for an early operation. Children convelescing from an attack of non-operated appendicitis should not be taken to any resort where a competent surgeon is not within immediate reach. Danger always lurks behind a diseased appendix.

### Correspondence.

My dear Doctor Bevan.—I was very sorry not to have had the pleasure of seeing you and to say goodbye the other night, but before I realized it, you had retired and I did not want to disturb you after that. I beg again to assure you that the Tri-State Chapter of N. Y., N. J. and Conn. were very glad to have had you present at their first annual meeting and hope that you will come to see us again. Every one of us is very much interested in our alma mater and its continued success.

I am sending you under separate cover copy of the May issue of my journal, containing the paper: "Appendicitis in Children" presented by Dr. Sheffield. Dr. Sheffield would be very glad to have this paper published in the next issue of the Alumni Journal. I am also sending you copy of a former issue of *Pediatrics*, containing a paper read by myself at the Newark meeting of this Society.

I also enclose herewith a little leaflet descriptive of a book which the F. A. Davis Company have just brought out for me. If you think it worth while, I will have the publishers to send you a complimentary copy. It would be a valuable pocket companion for a recent graduate in medicine and, I believe, be a means of stimulating in the young practitioner the habit of prescribing pharmacopæial preparations rather than writing for proprietary substances of unknown composition although of elegant appearance. Regretting that I did not have the pleasure of seeing you on Saturday night, as intended, I am,

Very truly and sincerely yours, W. E. Fitch, M. D. WILLIAM S. GARDNER, M. D., EDITOR, 6 W. Preston Street.

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## THE JOURNAL

### OF THE ALUMNI ASSOCIATION

OF THE

## COLLEGE OF PHYSICIANS AND SURGEONS, BALTIMORE.

#### THE EVER PRESENT MILK PROBLEM.

This is the season of the year when both the profession and the laity begin to wish that they had paid more attention to the subject of pure milk. This is the season in which they make good resolutions not to let another year pass without doing something and then the cold weather comes and the diarrhea ceases and the deaths are forgotten and the milk remains bad as ever or nearly as bad. Each year brings us nearer the time when we will take a common sense view of health matters. Just at present it seems that quite a large number of inhabitants rather enjoy having typhoid and having their children have intestinal disturbances, but the time is certainly approaching when not only the medical profession, but the laity as well will take hold of the milk problem in a vigorous manner and when once the importance of it is realized there is no doubt that the needed reforms will be accomplished.

After all the only two things that need really be considered are cleanliness and cold. There are two classes of people who retard progress, and one is the dirty farmer who doesn't know how to produce clean milk and probably wouldn't if he could, and the second is the dirty milk dealer who does not know how to keep his milk properly and who probably would not even if he did know. There is no room for these two classes of people and they should be compelled to clean up or quit. There is an excellent opportunity for the alumni to make local reputations by starting crusades for clean milk, and one of the first steps in this crusade is to secure one or more good milk supplies for the community so that those people who prefer to buy clean milk will know where to go.

This is best accomplished by certifying the milk by means of a milk commission or in absence of the commission by publishing from time to time the results of inspection. The second step is the difficult cleaning up of the small dirty dairy, and the small dirty milk shop and this will only be accomplished by wise legislation and the rigid enforcement of it. We should like to have any of our alumni who enter into this milk crusade to write to the Journal and send in their experiences.

#### MERCY HOSPITAL COMMENCEMENT.

The commencement exercises of the Mercy Hospital Training School for Nurses were held Tuesday evening, May twenty-eighth, in the Loyola College Hall, and diplomas were presented by the Dean of the Faculty of the College of Physicians and Surgeons, Dr. Charles F. Bevan, to the following graduates: Misses Nellie E. Sayre, West Virginia; Clara A. Boyle, Pennsylvania; Matilda D. Maslin, Maryland; Virginia Maslin, Maryland; Anna M. McCann, Pennsylvania; Pauline Lee, Maryland; Margaret A. Duddy, Pennsylvania; Cora Hannah, West Virginia; Mary R. Burinsky, Maryland; Agnes Boland, Maryland; Mary Boyle, Pennsylvania; Bessie McNutt, Maryland; Helen M. Nottingham, Maryland.

The medal for Theory and Practice of Nursing was awarded to Miss Bessie McNutt.

The opening prayer was made by Rev. P. C. Gavan, Chancellor of the Archdiocese; an address followed by Rev. William J. Ennis, President of Loyola, who greatly encouraged the class as being the official assistants and representatives of the physician in the sick room. The Dean followed with well-chosen words, which made his advice to the young ladies, as he delivered the diplomas, very impressive. Dr. William S. Gardner, then gave a vivid history of the progress of the college and hospital in the advance of surgical and medical nursing.

The exercises were closed with benediction bestowed by Rev. P. C. Gavan.

#### THE ANNUAL DINNER.

The annual dinner of the Alumni Association was held at the Hotel Rennert at 8.30 P. M. Dr. John D. Blake, '75, was toastmaster and in an

interesting preamble compared medical teaching of to-day with conditions in '75, dwelling upon the advance and progress of the P. & S. during the years which have passed since then. Dr. Luther H. Keller, '75, responded for the class of '75 in a delightful talk. He claimed, however, that Dr. Blake had stolen his thunder and said all the things which he would have said. Dr. Peter L. Keough, the class valedictorian, '12, addressed the faculty and his classmates with sentiments of appreciation for the companionship and pleasant relations and the regret that the hour of parting had come. After this Dr. Stokes made apologies for the faculty in verse. He was followed by Dr. Wm. Simon, who having just returned from Panama, told interesting things about the Big Ditch, about the medical work, and especially about our own Dr. Sam Darling. He averred that the man behind the microscope made the work possible. Dr. Chambers disclaimed any great responsibility on the part of the faculty in turning out good doctors; he insists that the material is good when we get it and the faculty adds the fringes. Interesting remarks were made upon call of the toastmaster by Dr. Wm. J. Todd, '89, Dr. Harry Friedenwald, '86; Dr. J. D. Chason, '88, Dr. W. P. McIntosh, '82, Dr. T. R. Paganelli, '03.

Among those present were: Dr. Wm. P. McIntosh, P. H., M. H. S., '82; Dr. Geo. D. Howe, '92, Rhode Island; Dr. A. B. Shatto, '95, Pennsylvania; Dr. H. G. Stetson, '95, Pennsylvania; Dr. W. H. Minnick, '90, Pennsylvania; Dr. L. J. Rosenthal '01; Dr. A. G. Rytina; Dr. Sam. Schmidt, '01; Dr. M. D. Silver, '02, Michigan; Dr. Geo. E. Hardy, '89; Dr. T. R. Paganelli, '03, New Jersey; Dr. Geo. A. Strauss, '08; Dr. E. G. Braddock, '09, Pennsylvania; Dr. Luther H. Keller, '75, Maryland; Dr. Frank Bellville, '75, Delaware; Dr. Byron Walling, '75, Maryland; Dr. Wm. J. Todd, '89; Dr. J. D. Chason, '88, Georgia; Dr. Tom Chambers; Dr. Jno. D. Blake, '75; Dr. Edgar Friedenwald, '03.

Dr. Paganelli is the secretary of the Tri-State Medical Association representing New York, New Jersey and Connecticut and composed of alumni of our college. The association is in a very flourishing condition.

Dr. A. C. Lewis, '93, is chairman of the Board of Health of Fall River, Mass.

Dr. Jno. C. Coughlin, '85, of Fall River, is a member of the National Committee (Dem.).

Dr. Jno. J. Gorman, '08, is school inspector in Fall River, Mass.

Dr. J. J. Kerrigan, '06, is a member of the Board of Health of Fall River, Mass.

Dr. A. W. Crews, '12, has located with Dr. J. W. Mankin in Thurmond, West Virginia.

Dr. J. A. Riffe, '09, is surgeon for the Fire Creek Coal Co. & Berry Bros. Coal & Coke Co., at Fire Creek, W. Va.

Dr. Jas. H. Walsh, '10, is bacteriologist in the Fall River City Hospital.

### ALUMNI AT ATLANTIC CITY.

The meeting of the American Medical Association at Atlantic City was very largely attended by P. and S. alumni. Room was reserved at Young's Hotel and altogether seventy-seven registered. 1875 is the earliest year mentioned. The following members registered:

Lonzo O. Rose, '01, Parkersburg, W. Va.

A. F. Ries, '03, Baltimore, Md.

Robt. H. Owens, '02, Baltimore, Md.

C. Hampson Jones, '90, Baltimore, Md. W. E. Fitch, '01, New York City.

W. T. Owens, '08, Mt. Clare, W. Va.

O. S. Brown, '86, Warren, Pa.

Alexius McGlannan, '95, Baltimore, Md.

A. T. Gundry, '94, Catonsville, Md. Thomas W. Brockbank, '85, Germantown, Pa.

J. W. Lacy, '96, Lisbon, Howard Co., Md.

Chas J. Sawyer, '95, Windsor, N. C.

A. C. Harrison, Baltimore, Md.

H. H. Haynes, '08, Clarksburg, W. Va. J. W. Preston, '93, Roanoke, Va.

D. G. Preston, '07, Burnwell, W. Va.

A. C. Gillis, '04, Baltimore, Md.

S. Waterworth, '93, Clearfield, Pa.

G. H. Witter, '85, Wellsville, N. Y.

Harry Friedenwald, '86, Baltimore, Md.

Chas. E. Brack, '95, Baltimore, Md.

M. J. Morrissey, '97, Hartford, Conn.

Wm. A. M. Miller, '03, Charleston, W.

William S. Gardner, '85, Baltimore, Md.

Frank Dyer Sanger, '88, Baltimore, Md.

Wm. T. Morrissey, '09, Unionville, Conn.

Geo. L. Broadrup, '91, Cumberland, Md.

J. C. McAllister, '89, Ridgway, Pa.

J. H. Doyle, '02, Fall River, Mass.

A. G. Barrett, '00, Baltimore, Md.

H. G. Stetson, '95, Greenfield, Mass.

M. D. Silver, '02, Detroit, Mich.

J. D. Chason, '88, Bainbridge, Ga.

A. J. Stewart, '04, Salt Lake City, Utah.

C. T. Horn, '78, Lehighton, Pa.

J. W. Chambers, '78, Baltimore, Md. Harvey G. Beck, '96, Baltimore, Md.

A. P. Butt, '95, Davis, W. Va.

M. D. Norris, '92, Eldersburg, Md. Chas. F. Blake, '93, Baltimore, Md.

H. C. Haning, '94, Dayton, Ohio.

Lewis H. Gundry, '90, Baltimore, Md. John H. Carman, '81, Plainfield, N. J. J. Williams Lord, Baltimore, Md. A. W. Colcord, '93, Clairton, Pa. Chas. B. Smith, '91, Washington, N. J. Emil Novak, Baltimore, Md. Julius Friedenwald, '90, Baltimore, Abdon V. Piskorski, '02, Jersey City, N. J. M. B. Kelly, '03, Wheeling, W. Va. G. W. Mitchell, '96, Baltimore, Md. Philip L. Chancellor, '01, Chicago, Ill. Richard F. Gundry, '88, Catonsville, Md. Spencer M. Free, '80, DuBois, Pa. Otto Schaefer, '94, Baltimore, Md. F. J. Snyder, '87, York, Pa. A. G. Rytina, Baltimore, Md. F. H. Coops, '96, Bridgeport, Conn.

Reid Hunt, '96, Washington, D. C.

Jno. D. Blake, '75, Baltimore, Md.
French S. Cary, '06, El Paso, Tex.
A. W. Lamy, '08, Elizabeth, N. J.
M. A. Bailey, Hartford, Conn.
W. E. Delaney, '91, Slate Run, Pa.
L. H. Keller, '75, Hagerstown, Md.
J. F. Bell, '85, Williamsport, Pa.
Chas. J. Cumings, '93, Williamsport
Pa.
Edward W. Sprague, '03, Newark, N. J.
J. P. Monroe, '01, Sanford, N. C.
Theo. J. Cumings, '03, Plattsburg,
N. Y.
J. W. Mankin, '06, Thurmont, W. Va.
Geo. H. Reinhardt, '04, Baltimore, Md.

John Ruhräh, Baltimore, Md.

Dr. Lockwood, Baltimore, Md.

B. D. Evans, '85, Greystone Park, N. J.

### GRADUATING CLASS 1912.

Adkins, Asa W.......West Virginia. Anderson, Andrew A.....Utah. Beal, David O......Utah. Brillhart, Harry S.....Pennsylvania. Bennett, Edward C....West Virginia. Biffar, Harry M.....New York. Bannister, J. H......West Virginia. Brown, J. S.....Pennsylvania. Coughlin, Chas. F. J..... New York. Christopherson, W......Utah. Craig, J. S......West Virginia. Cooper, E. R......West Virginia. Crews, A. W...........West Virginia. Driscoll, W. T.....Connecticut. Dubroff, M. A.....New York. Eisner, Maurice S..... Massachusetts. Evans, A. M.....Maryland. Friedman, Louis......Maryland. Friedman, Louis M.....New York. Goldstein, Albert E.....Connecticut. Gerhart, Wm. F......Pennsylvania. Guthrie, Jas. K......West Virginia. Hanna, B. S......Maryland. Hillis, F. N......Virginia.

Ireland, Ritchie A....West Virginia. Janer, Manuel R.....Porto Rico. Johnson L. Dale.....Pennsylvania. Kuhlman, M. W.....Pennsylvania. Kimsey, Fritz J.....Tennessee. Kohler, G. A., Jr.....Pennsylvania. Keough, Peter L.....Rhode Island. Little, A. W., Jr.....New Jersey. Long, B. H.....Pennsylvania. Levine, S. S......Connecticut. Mendeloff, M. I......Maryland. Man, Albert E.....Pennsylvania. Morris, Saml. J.....West Virginia. Norris, Lester F..... Massachusetts. O'Brian, Thos. J.....Rhode Island. Paul, Frank......Maryland. Post, Cecil O......West Virginia. Quillan, Otis L.....Ohio. Reeser, N. B.....Pennsylvania. Roberts, S. J.....Pennsylvania. Sweet, Grover C......Connecticut. Smith, Edward P.....Pennsylvania. Sheahan, Wm. L., Jr....Connecticut. Spearman, John F....Pennsylvania. Spangler, Paul C.... West Virginia.
Schwartz, Leonard O. Pennsylvania.
Spinks, J. M.... West Virginia.
Scott, George V... West Virginia.
Sprowls, G. M... Pennsylvania.
Shannon, A. C... Pennsylvania.
Sullivan, Leo J... Massachusetts.
Sooy, John L... New Jersey.

Thompson, Earl X.....Maryland.
Vinicombe, Harry W....New York.
Wheeler, G. B....West Virginia.
Williams, M. B....West Virginia.
Wilson, J. E....Pennsylvania.
Wurtzel, Geo. L....New York.
Zimmerman, Curtis L. Pennsylvania.

#### COLLEGE PRIZES.

Edward P. Smith, Pa.....1st Prize. W. Christopherson, Utah....2d Prize.

Manuel R. Janer, Porto Rico.3d Prize. M. W. Kuhlman, Pa.....4th Prize.

#### WORTHY OF HONORABLE MENTION.

L. Dale Johnson	Pennsylvania.
Louis Friedman	Maryland.
C. F. J. Coughlin	New York.
M. S. Eisner	.Massachusetts.
J. S. Craig	. West Virginia.

## MEMBERS OF THE CLASS OF 1912 WHO HAVE RECEIVED HOSPITAL APPOINTMENTS.

Dr. Harry M. Biffar, Eastern District Hospital, Brooklyn, N. Y.

Dr. Andrew A. Anderson, Mercy Hospital, Baltimore, Md.

Dr. Harry S. Brillhart, Mercy Hospital.

Dr. Jos. S. Brown, Mercy Hospital.

Dr. Chas. F. J. Coughlin, Mercy Hospital.

Dr. W. T. Driscoll, Mercy Hospital. Dr. M. A. Dubroff, Marine Hospital,

New York.

Dr. A. M. Evans, Mercy Hospital.

Dr. Albert E. Goldstein, Hebrew Hospital.

Dr. Wm. F. Gerhart, Roosevelt Hospital, New York.

Dr. Ritchie A. Ireland, Mercy Hospital.

Dr. M. W. Kuhlman, Mercy Hospital.Dr. G. A. Kohler, Mercy Hospital.Dr. Peter L. Keough, Memorial Hospital, Jersey City, N. J.

Dr. Sinclair S. Levine, City Hospital, Hartford, Conn.

Dr. Albert E. Man, State Hospital, Scranton, Pa.

Dr. Thos. J. O'Brian, Mercy Hospital. Dr. Frank Paul, St. Joseph's Hospital, Baltimore, Md.

Dr. Grover C. Sweet, St. Vincent's Hospital, Bridgeport, Conn.

Dr. Edw. P. Smith, Mercy Hospital.

Dr. Jno. F. Spearman, Mercy Hospital.
Dr. Wm. L. J. Sheahan, Eastern
District Hospital, Brooklyn, N. Y.
Dr. Geo. V. Scott, Christ Hospital,

Jersey City, N. J.

Dr. Alex. C. Shannon, Mercy Hospital. Dr. Leo J. Sullivan, City Hospital, Fall River, Mass.

Dr. M. B. Williams, Mercy Hospital.Dr. J. E. Wilson, Christ Hospital, Jersey City, N. J.

Dr. Geo. L. Wurtzel, Peoples Hospital, New York.

#### THE REUNION OF 1875.

#### A LETTER FROM DR. BLAKE.

1014 W. Lafayette Ave., Baltimore, Md.

Dear Dr. Brack.—Thinking it might be of interest to the Alumni of 1875, I desire to say regarding our class reunion that while we had hoped to have a large proportion of those now living present with us, we were much gratified at having even the few who found it possible to attend upon that occasion. Those in attendance were:

B. W. Walling, Poolesville, Md.; L. H. Keller, Hagerstown, Md.; Frank Bellville, Delaware City, Del.; J. Miller Hyson, Red Lion, Pa.; Z. K. Wiley, Baltimore, Md.; J. E. Person, Pikeville, N. C.; and Professors Charles F. Beyan and D. W. Cathell.

On Friday morning, May 31, 1912, I wended my way to the Hotel Rennert (our headquarters) and looking over the register was delighted to find the names of Person, Bellville and Keller inscribed thereon, soon to be followed by that of Hyson. I reported at once to their suite of rooms where we all joined in a guessing match as to who we were. It did not take us long, however, to discover the identity of each, as we all bore some distinguishing feature which had not been quite effaced by time which enabled us to recognize each other as members of the class of '75. Keller and Bellville, whom we all remember, during class days could always be relied upon to break the monotony of any occasion gave striking evidence of their old traits and were soon busily engaged in their bantering tactics to the amusement of the whole number. Wiley about this time loomed up and added to the merriment of the occasion. Leaving the Hotel Rennert, after becoming thoroughly reacquainted, we proceeded to the College of Physicians and Surgeons where we received a cordial welcome by Prof. Bevan (the Dean), when we were shown through the entire building including the kitchen and dining room of the hospital, and the extensive changes that had taken place since our day in the medical school. From there we piloted them around on Fayette Street where we partook of lunch, after which we took them over the burnt district, visiting the old college site, Hanover and Lombard streets, and then boarding a car we proceeded to Riverview Park where we enjoyed for a brief period the many attractions to be seen and had there. On our return to headquarters we donned our glad rags preparatory to the reunion banquet which took place at 7 p. m., and at which, we were delighted to have as our guests Professors Bevan and Cathell, the only living members of the old faculty who were able to attend. This was an intensely interesting occasion. The past was rehearsed and we said lots of nice things about each other and about the class of 1875. I was honored with the position of toastmaster and was ably assisted by the ever-ready and witty Keller and by the somewhat retiring and modest bachelor of the class, Hyson. This feature of the occasion was terminated about midnight. On Saturday morning we reported again at headquarters, as previously arranged, with two automobiles and the boys taken from there to the Maryland General Hospital, with which I am connected, and after an inspection of that institution and of the Baltimore Medical College we returned to the autos and after a ride through the northern part of the city, Charles-Street Avenue to University Parkway, to Roland Park, returning through Druid Hill Park (the most natural park in the world) stopping long enough to inspect very carefully the camels, bears, the sacred cattle, the monkeys, which seemed to impress Bellville and Walling and caused them to make some invidious comparisons. We returned to the city to lunch at my home where we were joined by Prof. Cathell, and after lunch proceeded across the street to Lafayette Square where we were seated and our photos taken. Since which time each one present has been furnished with a copy of said photo and pronounced by all who have been permitted to gaze upon it as the most professionally looking crowd that has assembled in this section for these many years. It was now about 3.30 p. m. when the autos were brought into requisition again and we proceeded to the Lyceum Theater and there given a seat of honor at the commencement exercises of the class of 1912 of the College of Physicians and Surgeons. From there we proceeded to the Rennert and at 7.30 p.m. were entertained at the class dinner of the college where we spent a time never to be forgotten. About midnight we adjourned and after a few more pleasantries we all shook hands bidding each other an affectionate farewell, thus ending the one of the most pleasant and enjoyable occasions that it has ever been our pleasure to experience. It was a source of much regret on the part of every one to find that so many of the graduates of 1875 had passed away since the date of our graduation. That

quite a number are now lying upon beds of affliction, and still a greater number were so environed that at the last moment they were prevented attending this reunion.

Sincerely yours,

JULY 1, 1912.

JNO. D. BLAKE.

### COLONEL CHARLES JACOBUS HALPER.

It gives us pleasure to reprint the following article from *The Eastern Elk*. The colonel will be remembered by everyone who was about the college during the early nineties and all will be pleased to know that he is "A Three-Time Exalted Ruler":

#### CHARLES J. HALPER.

POPULAR AND EFFICIENT RULER OF DERBY, CONN., 571, WHO IS NOW FINISHING HIS THIRD TERM AS EXALTED RULER.

In his passing from the chair of exalted ruler, Derby, Conn., 571 feels that it has lost a beloved leader, a wise counsellor an efficient executive officer and, above all, a true exponent of that sociability so dear to Elkdom and so characteristic of the ideal Elk. Three terms has Charles J. Halper filled the highest chair in his lodge and he could have had a fourth had he but said the word.

Charles J. Halper is a native of New York City. He was born there on Oct. 7, 1871. When he was but one and one-half years of age his parents removed to Connecticut. His father was the late Samuel Halper and one of the pioneer merchants of Derby.

Brother Halper attended Derby public schools, primary, grammar and high and later the Yale Business College from which he was graduated with high honors. In 1889 he entered the College of Physicians and Surgeons at Baltimore, Md., and was about to be graduated when his father died. Abandoning the profession of medicine, Brother Halper took charge of his father's business.

He became a member of Derby Lodge of Elks in 1901 and soon passed through the chairs. In 1905 he was elected exalted ruler after a spirited contest. He at once proved himself a model exalted ruler and was directly instrumental in bringing to Derby Lodge the rare degree of prosperity it at present enjoys. His enthusiasm as an Elk is unbounded. Many of the improvements of his lodge he paid for out of his own pocket. For one Memorial Day service he rented the Derby Opera House, paying the rental from his own purse. Upon finishing his first term the brothers gave to him a gold, diamond studded life membership card but he refused to accept it unless he was allowed to pay for it, which he did thus establishing another precedent.

At the Grand Lodge in Denver, Col., Brother Halper represented his lodge with marked ability.

When lodge affairs looked badly in 1910 it was to Brother Halper his brethren appealed and not in vain. He was re-elected exalted ruler and soon restored prosperity to the lodge. A baseball fan, he organized a crack Derby Elks' nine, playing several snappy, close games with the Bridgeport, 36, team. He created social functions galore; free band concerts, pool, whist and billiard tournaments and many splendid ladies' nights.

He initiated more new members than any other exalted ruler Derby has had. He was instrumental in securing and so sumptuously furnishing Derby Lodge's splendid rooms. He was the founder of the Elks' Bungalow, now the Country Club, on the Housatonic River.

Brother Halper is a member of several other fraternal orders and an honorary member of Hotchkiss Hose Company, No. 1 and the Bacillus Club of the College of Physicians and Surgeons, in Baltimore. He is a member of King Hiram Lodge, F. and A. M.; Valley Lodge, K. of P.; Camp Lawson, No. 14, Spanish War Veterans and the Derby Board of Trade and Business Men's Association. He was hospital steward throughout the Spanish-American War.

In 1911 Brother Halper was re-elected exalted ruler for his third term. He has rarely missed a lodge meeting nor been late. It is with the unfeigned regret of every member of Derby Lodge that he retires at this time.

Brother Halper, on February 25, became a benedict. He married Miss Frances Keppler, of New York City, a most charming and accomplished young woman.

Charles J. Halper is, and always will be, a strong and ideal example of true Elkdom.

#### THE TRI-STATE CHAPTER.

The annual dinner was very successfully brought to a close by a short meeting held in one of the assembly rooms of the Hotel Manhattan, Forty Second Street and Madison Avenue, New York City, on May 25, 1912.

President Fitch called the meeting to order and the program of the evening followed.

Dr. H. B. Sheffield read an elaborate paper on Appendicitis in Children. Prof. Chas. F. Bevan, Dean of the Faculty of the College, Baltimore, was first to discuss this paper, which he did in true and well-known Bevan style. He was followed by Dr. O'Hara, of Bridgeport, Conn.; Dr. Hugh F. Cook, Newark, N. J.; Dr. Carman, Plainfield, N. J.; Dr. Luther, of New York City; Dr. Malone, of Brooklyn, and Dr. O'Hanlon, Superintendent Bellevue and Allied Hospitals of New York City.

Dr. Sheffield closed the discussion.

Dr. O'Hara, of Bridgeport, Conn., spoke on Tri-State Chapter, Alumni C. P. & S. (N. Y., N. J. and Conn.). Dr. Hugh F. Cook, of Newark, N. J.,

spoke on Fostering of Mutual Interests Among the Alumni. Dr. Gallison spoke on Reminiscences of College Days.

An address by Prof. Chas. F. Bevan followed. He spoke at some length on the standing of the college and reported many interesting matters which were particularly pleasing to the Tri-State Chapter.

A communication was read of Dr. Sprague wherein he suggested a Special Lecture Fund. This matter was referred to the executive committee.

A communication of Dr. Alexius McGlannan was read which suggested having a meeting in Baltimore, Md., about commencement time. Owing to the brief time to make arrangements it was decided to abandon this meeting. Dr. Gallison made a motion seconded by Dr. Sheffield that the next meeting be held in New York City on the second Wednesday in October.

Meeting adjourned.

The members present were as follows: Dr. W. E. Fitch, President Tri-State Alumni; Dr. Chas. F. Bevan, Professor of Surgery, Dean of Faculty, College of P. & S., Baltimore, Md.; Dr. H. B. Sheffield, New York City; Dr. L. Ely, Summerville, N. J.; Dr. Hugh F. Cook, Newark, N. J.; Dr. Wm. J. A. O'Hara, Bridgeport, Conn.; Dr. J. G. Gallison, New York City; Dr. J. Gorse Simmons, New York City; Dr. A. C. Palmateer, New York City; Dr. Jos. W. Malone, Brooklyn, N. Y.; Dr. George O'Hanlon, Superintendent Bellevue Hospital; Dr. Ernest H. McDede, Newark, N. J.; Dr. John J. Bourne, Newark, N. J.; Dr. J. C. Fisk, New York City; Dr. B. B. Finkelstone, Bridgeport, Conn.; Dr. H. R. Mutchler, Passaic, N. J.; Dr. Chas. B. Smith, Washington, N. J.; Dr. K. Arvid Enlind, New York City; Dr. F. M. Luther, New York City; Dr. F. W. Lockwood, East Orange, N. J.; Dr. J. H. Carman, Plainfield, N. J.; Dr. T. Richard Paganelli, Hoboken, N. J.

## Personal Motes.

Dr. Wm. F. Lockwood has been elected Dean of the faculty for the ensuing year in place of Dr. Charles F. Bevan who has been Dean continuously since the resignation of Dr. Thomas Opie.

THE F. A. DAVIS Co., Philadelphia, have issued a new medical formulary which has been compiled by William Edward Fitch, of New York. This little volume contains over 2000 signed formulæ culled from the writings and teachings of the leading physicians, surgeons and specialists in this and other countries.

DR. SPENCER M. FREE, '80, of Dubois Pa., sailed for Europe on the steamship Maine on June 27. Dr. Free will spend most of his time in Berlin. If we are correctly informed he, while there, will give his friend William several pointers on music, art and politics and probably engage in a contest in writing poetry. A special concert will be given in his honor by the Imperial Military Band, which, upon this occasion, will play several of Dr. Free's famous compositions.

## Dbituary.

Dr. Amos Burr Straight, '91, a member of the Medical Society of the State of New York, and one of the best-known practitioners of Western New York, formerly a clergyman of the Methodist Episcopal Church, died suddenly at his home in Hornell, January 9, from heart disease, aged 45.

Dr. Jefferson Dudley Poindexter, '86, a cadet at the United States Military Academy, West Point, N. Y., in 1883 and 1884, who entered the Medical Corps of the army in 1887, and was made captain in 1892, was retired with the rank of major in 1901 on account of disability in line of duty and since his retirement has been a resident of Danville, Va., died at his home in that place, September 10, 1911, aged 45.

### Correspondence.

New York, May 28, 1912.

Dear Doctor Bevan.—I hope you arrived home safely and in good health. It was rather audacious on our part to urge upon you to attend our meeting, but I felt it would afford you great pleasure to see that "your boys" have not forgotten the alma mater and highly appreciate all that you have done for them. I can hardly describe how happy you made us all, each one of us, by your presence, and it will certainly serve as a great incentive to cement the fellowship of our boys and to help to promote the welfare of the college. Ever grateful to you and to the faculty for the good will and wishes, I am, with highest esteem and sincere regards,

Yours very sincerely,

H. B. SHEFFIELD.

### North Loup, Nebraska, January 16, 1912.

W. E. MAGRUDER, Esq., M. D., Secretary Baltimore City Medical Society.

My Dear Dr. Magruder.—I am enclosing herewith draft on Omaha for \$10.00 being the amount due the society by me for dues to January 1, 1913. Shall be glad if you will at your convenience acknowledge same.

I am located temporarily in this section, having come here last April. The location is a little beyond civilization, as we understand it in a larger city, but there are good opportunities for getting some quick money and a wealth of experience. The community is in the midst of a large farming and stock raising section and the town of North Loup named on account of its proximity to the Loup River, is the shipping point for large quantities of hogs and cattle. The section also produces seven-tenths of the pop corn used in the country, and between the stock, pop corn, and other varieties of corn grown, the country has grown to be quite a wealthy one.

Our roads are uniformly good, and a car can be used most of the time, although I use a double team occasionally. Probably a little experience of my practice here may not be amiss, and will illustrate a condition which I am sure one seldom meets with in the city. On December 23 I was called at 2.30 o'clock in the morning to consult over a case 16 miles away. The thermometer stood at 16 below, and I had to make the trip in a team over mighty slippery and hilly roads. The man was suffering from a meningitis following a middle ear condition. The attending physician having to go away to Grand Island, 40 miles from base, to see a patient he had recently operated upon, asked me to take charge of the case for the day. We had

decided on an operation and had wired for an "ear man" to come over to Scotia, the nearest town, as soon as possible, he arriving at 6 that evening. I returned home and covered the course again midday in a "Mitchell 40," returning the same evening by team to assist at the operation, getting home at 3 o'clock Sunday morning. I had covered that day over 100 miles, with team and auto with the mere mercury down to zero. How's that for practice?

Yet the experience one gets here is worth a great deal. It puts one on his mettle and brings out all that there is in a man in time of necessity.

I will not take up any more of your time, but will ask you to remember me kindly to those of the P. & S. who remember me, and as soon as I gather in sufficient of the *sheckels* to make a good stand in a larger place, will come Baltimorewards again to shake hands with all my former acquaintances.

Faithfully

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#### THE HAY-FEVER RIDDLE.

Despite the many therapeutic advances of recent years, "what to do for the hay-fever patient" continues to be something of a puzzle. The long-sought specific still eludes us. Nevertheless, the malady is not quite the enigma that it once was. Medication, if still empiric, is not ineffective. The symptoms of the disorder can be controlled or minimized; relief, though temporary in many cases, may be obtained; and for these blessings the afflicted patient and the sympathetic physician may well be thankful.

For use in the treatment of hay-fever there is, of course, a long line of socalled available medicaments. One dependable agent which comes naturally to mind in this connection is Adrenalin. Indeed, it is doubtful if any other single medicinal substance has been so largely and successfully employed in the treatment of vasomotor rhinitis. As adapted to the needs of the hay-fever sufferer the product is available in a number of convenient forms, as Adrenalin Chloride Solution, Adrenalin Inhalant, Anesthone Cream, Anesthone Inhalant, Anesthone Tape, etc. The various solutions are used in spraying the nares and pharynx, the cream for snuffing into the nostrils, the tape for packing the nostrils. All cases of hay-fever, of course, are not amenable to the same form of treatment. It is a logical presumption, however, that a vast majority of them ought to yield to one or more of the preparations above referred to. The Adrenalin products, as is well known to most physicians, are manufactured by Parke, Davis & Co., who will doubtless be glad to send literature regarding them to any practitioner. Requests for printed matter may be addressed to the company at its main offices and laboratories in Detroit, Mich.

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Adrenalin Chloride, 1 part; physiological salt solution (with 0.5% Chloretone), 1000 parts. Dilute with four to five times its volume of physiological salt solution and spray into the nares and pharynx. Ounce glass-stoppered bottles.

Adrenalin Inhalant

Adrenalin Chloride, 1 part; an aromatized neutral oil base (with 3% Chloretone), 1000 parts. Dilute with three to four times its volume of olive oil and administer in the manner Ounce glass-stoppered bottles. described above.

Anesthone Cream

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Anesthone Tape

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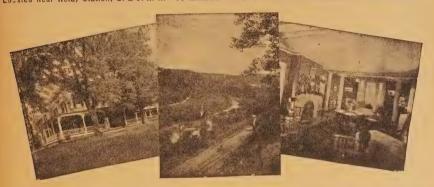


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NEED BUSINESS QUALITIES INTERFERE WITH THE SUCCESSFUL PRACTICE OF MEDICINE?\*

BY CHARLES J. CUMMINGS, M. D., WILLIAMSPORT.

What are business qualities as here meant, and what constitutes a successful practice of medicine? For the purpose of this paper let us say that the term business qualities means a sort of business acumen, the exercise of which aims at husbanding one's professional earnings and wisely investing the same.

To understand the full significance of the term successful practice of medicine, and to analyze and intelligently answer the question herein before outlined, we shall review the professional careers of two busy practitioners, Doctor A and Doctor B.

Both were college men with brilliant careers in which they had won the honors of their class. Both graduated with equal distinction from a reputable medical school, and each received a thorough hospital training.

They were alike intelligent, industrious, progressive young men and, as we have seen, thoroughly fitted and equipped, so far as schooling and preliminary training could fit and equip them, for the practice of medicine.

Armed with their diplomas and bouyed up by that self-assurance so characteristic of the beginner, which tells them the world is now their very own, they at once entered upon the practice of their profession. They opened offices upon opposite sides of the prominent street in a prosperous and thriving city, and the proverbial "shingle" took its most appealing place. Each made rapid advancement in his profession, and gave early promise of a brilliant career.

<sup>\*</sup> Read at the general meeting, Medical Society of the state of Pennsylvania, Harrisburg session, September 27, 1911.

Soon it was noticed, however, that Doctor A was much the busier man. Competent, kind, considerate and generous, he early built up a large practice. It was a practice, however, which yielded an income sadly inverse to its growth and size. True, he won and received much fulsome praise and a sort of dubious honor and respect, but they were of the milk-and-water kind, and rather aggravated than cured the fatal malady that had at last overtaken him, "professional dry-rot."

During all the years of his practice he thought only of his patients, entirely indifferent to self. A mistaken idea of charity, ever the directing impulse in his charging of fees, and carelessness and neglectfulness in his collections, twin evils which have marked the ruin and defeat of many a promising doctor, soon showed their destructive and decaying influence upon the practice of Doctor A.

Funds ran low, quickly followed by discouragement, and then neglect. He became at once rusty in his professional knowledge, rusty in his office equipment, and rusty in his personal appearance. He could not afford to cast aside that old worn coat because his pompous patients, who had long owed him goodly sums, needed the money to deck themselves out in all the latest and costliest fashions of the day. And yet he loved meaningless praise and empty flattery. To be called good old charitable Doctor A was sweet music to his soul; sweeter indeed than the clink of coin in his pocket. He would never ask for a fee until necessity compelled, and then with the humblest and most profound apology for the offense.

Time with its cold, cruel indifference sped on and took no note of the tottering, struggling physician. At last the silver threads replaced the gold, and as the melancholy shades of life's evening fell around him, he awoke as from a dream to realize that he was a poor old man. Where now are all those he befriended, those so-called friends of his better days? All gone. Old, poor, deserted and alone, he now awaits the last call yonder across the "divide."

Doctor B, as we have said, graduated in the same class with Doctor A. He was equally well equipped and they began life's battle on equal terms. Dame Nature in her providential endowments willed more generously to Doctor B than she did to his larger hearted and kindlier natured classmate; she builded him of sterner stuff and bequeathed to him a keener appreciation and a larger knowledge of his fellow men.

It was not long until Doctor B had gained the enviable reputation of being a merciless charger, and a strenuous collector of fees. The fellow who did not intend to pay him well for his services, as well as that other less-desirable who had no intention of paying anything, invariably passed the office of Doctor B to prey upon the kindly and charitable Doctor A.

Times there were a plenty when storms would break around him as his fees and methods of collections were contrasted with those of Doctor A, but they were like the electrical storms of a sultry summer's day; they clarified his professional atmosphere.

Somehow the better portion of the medical clientele, that portion worth while, rather took to the big fee. They seemed to get the impression from his larger fees and stricter methods of collecting that somehow he was correspondingly a better doctor, had better medicines and possessed a superior surgical skill. Again, there was in this as in all communities a large army of human leaches, otherwise and better known as "deadbeats." These had all in their time received the professional services of kind old Doctor A for which they had never paid a cent, and now, lest they offend him by paying up, they would bring their loose change to Doctor B.

Doctor B's methods soon acted as a sort of sifting process by which the chaff and dead wood drifted to his easy-going neighbor, while the golden harvest of grain was all his own. This tact, this exercise of business qualities, not only brought him rich returns, but gave to him a little time for study, a little time for play, and a little time for the proper husbanding of the earnings of his profession.

He was progressive, up to date, and always gave to his patients the full benefit of a high order of medical and surgical skill. When this service was rendered, he insisted upon a sufficient and quick remuneration. He believed that a practice was not truly successful which looked only to the interest of the patient, leaving the interest and welfare of the doctor wholly without the accounting.

And so when Doctor B had scarce passed his noon-day of life, he had already accumulated a sufficient competency, and was rich in the genuine respect and esteem of his fellow men. His whole professional career was a typical exemplification of the principle that business qualities do not interfere with the successful practice of medicine, but indeed are essential elements of success.

As we have seen there was nothing of the executive in Doctor A. Business qualities had no part in his economic make-up. He knew no more about them than most of us do of the Egyptian pyramids. As to charity, he could not distinguish the sham from the genuine, and so it became to him a veritable *ignis fatuus*, that made of fortune a will o' the wisp, that ever took flight at his approach. Believing that you have all seen the original, I present the picture as an answer in the negative to the question: Need business qualities interfere with the successful practice of medicine?

### VENTILATION OF SCHOOL-ROOMS.\*

BY C. W. G. ROHRER, M. A., M. D., PH. D., BALTIMORE, MD.

INTRODUCTORY.

Mr. President, Ladies and Gentlemen:

"You'd scarce expect one of my age
To speak in public on the stage;
And if I chance to fall below
Demosthenes or Cicero,
Don't view me with a critic's eye,
But pass my imperfections by."

More than a century ago a member of your profession wrote the old, familiar verses from which I have just quoted. David Everett, a public school teacher away up in historic Massachusetts, wrote these words for one of his pupils—a little boy seven years old. They were spoken by this seven-year-old boy at an old-time school exhibition, the kind you and I used to go miles to attend. We still regret that those helpful, entertaining school exhibitions have become a thing of the past and are no longer given. David Everett, the author-school-teacher, can justly be called the "Edwin Markham of his generation."

Before proceeding further, I beg to assure you of the great pleasure it affords me to be present at this session of the Kent County Teachers' Institute. I am always happy to mingle with members of the time-honored profession of teaching. It is especially gratifying to learn that you are not

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only interested in "teaching the young idea how to shoot," but are also desirous of fostering the health of the pupils entrusted to your charge.

Yours is a sacred calling. But it is unnecessary for me to lay especial stress upon the holiness of your sacred calling. The very fact that you have requested this lecture, and your presence here this afternoon, bear testimony of your devotion to your profession and to the best interests of your pupils.

#### AIM OF EDUCATION.

Tillotson, the great master mind of two generations and a half ago, tells us that the true aim of education is "to fit us for complete living." Very good, indeed. But education may also be described as a two-edged sword cutting both ways for good or for evil. Education may be a blessing or a curse, according to the conditions under which it is obtained. To begin education too early is often detrimental to a child's health. What is likely to be the result? Why, the prodigy of the nursery becomes the fool of the family. Well did the great statesman proclaim, "We must educate, we must educate, or we must perish by our own prosperity!"

To proceed a step further: To educate the mind at the expense of the body borders upon the criminal; because health has no handicap in the race of life. To compel a tender, growing child to sit for hours in a stuffy, poorly ventilated school-room is inhuman, to say the least. Truly,

"Man's inhumanity to man Makes countless thousands mourn."

We have a very effectual Child Labor Law in the State of Maryland. Its proper administration is doing a vast amount of good. Maryland, however, should have a more definite law pertaining to school children, their age upon entering, the number of hours to be devoted to study, and above all things the sanitary condition of the school-room.

### MAN AN AIR-BREATHING ANIMAL.

Man is an air-breathing animal. Man requires oxygen for his existence. How shall he obtain the requisite amount of oxygen?

1. By spending in the open air as much as possible of his allotted three-score years and ten; and,

2. By providing for proper and effectual ventilation when it becomes necessary for him to be domiciled in the home, in the office, in the church, in the school-room, or in the public building.

#### WHAT IS VENTILATION?

Well might we ask the question, What is ventilation? Briefly stated, we may say that ventilation is the means resorted to for the dilution and prompt removal of impurities of the atmosphere within our dwellings. These impurities are derived principally from the pulmonary and cutaneous exhalations of men and animals, and from the products of combustion of lights. To illustrate the necessity for ventilation I wish to mention three extreme instances. One is the "Black Hole of Calcutta." The horrible story of the "Black Hole of Calcutta" is familiar to every one. Of 146 prisoners confined in a dark cell at night, only 23 were found alive in the morning. The second instance refers to the great battle of Auster-After the battle of Austerlitz 300 prisoners were crowded in a prison: 260 died in a short time from inhaling the poisoned air. The third is that of the steamer "Londonderry," in which, of 200 steerage passengers who were temporarily crowded into a cabin (18 x 11 x 7 feet) during a storm of only a few hours' duration, 72 were dead and others dying when the cabin was opened.

#### PURPOSE OF VENTILATION.

Besides being air-breathing, man is also a gregarious animal. The artificial conditions under which he lives necessitate that ample provision be made for ventilation. The health of his body demands it. It is also essential to his spiritual well-being.

Our first parents, Adam and Eve, lived in a garden. No stately mansion adorned the premises. The canopy of heaven was their only rooftree. Cain was a tiller of the soil; Abel was a keeper of flocks and herds. Both lived near to Nature and to Nature's God.

Consider the American Indian in his primitive condition. Those sturdy children of the forest lived largely out of doors. The pursuit of the chase furnished them food and sustenance. Did they breathe the foul air of the church, of the school-room, or of the poorly ventilated private residence? Not at all. The leafy groves were their first and only

temples. The book of nature was their school-book, and Dame Nature their teacher. They breathed the pure, ozone-laden air of the pine forest and of the boundless prairie, and breathed it abundantly. A healthier, hardier race of beings it would indeed be hard to find.

#### VENTILATION OF SCHOOL-ROOMS.

Among the most important of public health questions is the problem of ventilation. High up in the scale stands the ventilation of school-rooms. The pupils, earnest seekers after light and truth, and their busy teachers, spend from five to six hours daily in the school-room. This period represents nearly one-fourth of the twenty-four hours. How important, then, it becomes for both pupil and teacher that the school-room should be properly ventilated. How is this to be accomplished?

### How BEST TO VENTILATE?

Numerous patent ventilators are on the market. Some of these, while complicated and high priced, are really "fair to look upon." But their utility can be seriously questioned. In fact, I am only mentioning them to condemn them in a measure. For school commissioners to purchase patent ventilating devices and fit up school-room windows with them would be an unnecessary expenditure.

In order to ventilate a school-room properly the air must be kept constantly in motion. The air may be kept in motion and efficient ventilation secured—

- 1. By those forces continually acting in nature, producing natural ventilation. The three main forces of natural ventilation are diffusion, the winds, and the motion caused by the difference in weight of air of different temperatures. And,
- 2. By these main forces of natural ventilation in combination with other forces set in action by man, giving artificial ventilation.

Diffusion is constantly taking place between all the gaseous constituents and impurities of the air, and even goes on through brick and stone walls, but is insufficient in itself to keep the air pure, though it does much to further this object. Moreover, as suspended matters are solid, not gaseous, they are not changed or removed by it.

Winds are powerful agents for ventilation, and a slight breeze passing through a school-room changes the air therein many times in the course of an hour, and carries out by its force many of the solid impurities not affected by diffusion. Wind will pass through walls of wood, brick or stone, although its progress is markedly arrested by much moisture in the walls and by paper or plaster. In winter, however, the wind usually has to be excluded directly from our school-houses, because a velocity of five or six feet per second is not to be borne unless the air be previously warmed.

The most important agent in natural ventilation is the third one mentioned, namely, the movement produced by variations in the specific gravity of air. As the air expands when heated, it becomes lighter, volume for volume, and rises because the colder, heavier air pushes in beneath to occupy the space.

#### DIFFUSION OF GASES.

By this time it must be plainly evident that upon the law of diffusion of gases largely depend the principles underlying ventilation. Slightly stretching the meaning of the term, the wind might also be included under this head, it being produced by the same force.

Expired air, heated and warmed to body temperature and not unduly laden with moisture, has a tendency to rise toward the ceiling. This is a law in physics. It is what makes the smoke go upward. Warm air ascends and cold air descends; thus the warm air occupies the upper portions of a room and the cold or cooler air the lower portions, a condition of affairs which can be tested to one's entire satisfaction by mounting a chair or table in a heated room and attempting to pick an object from the ceiling.

#### PRACTICAL APPLICATION.

Bearing in mind the law of diffusion of gases, you at once have at your fingers' ends the best method of natural ventilation. Tersely stated, how can we best apply this principle to the ventilation of school-rooms? I will tell you. Lower the school-room windows from the top, a few inches or more, according to the season, to allow the warm, expired air to escape. Also raise the windows slightly from the bottom to permit fresh air to

enter from without. If the wind is high and the weather extremely cold, the windows need not be raised from the bottom. A sufficient amount of fresh air will enter between the upper sash and the lower one.

The above is a broad, general statement and applies especially to school-rooms of moderate dimensions. For larger school-rooms it can also be accepted, however, with certain modifications.

A proper system of ventilation must take into consideration the cubic space of the school-room to be ventilated, and the number of pupils ordinarily inhabiting this space. Concerning Kent County, there is scarcely a public school-room in Kent County which cannot be properly ventilated by means of natural ventilation, which I have just described. If natural ventilation proves to be inadequate, artificial means must be resorted to. Here again the simple rule applies: The air in the school-room must be kept in gentle, continuous motion. So simple a contrivance as an electric fan helps to bring about this consumation.

#### ARTIFICIAL VENTILATION.

Certain large buildings have a so-called *cowl* or *ventilator* fixed in the ceiling near the dome, occupying very much the situation of the ordinary skylight. This allows a ready escape for the warm, expired air. Unless the fresh air is admitted near the floor, and warmed as it enters, such a system of ventilation is likely to reverse the old proverb, "Keep the head cold and the feet warm." But it must be an exceptionally large school-room that would require a ventilator in the roof.

The old-fashioned, open fireplace was one of the best ventilators. It is not at all surprising that Charles Dudley Warner should have written that it is impossible to rear a boy or a girl properly without an open fireplace with its rusty iron grate and luminous back-log.

But the old-fashioned fireplace exists no more, save in the memory of us who are no longer boys and girls. There reign in its stead the coal stove, the furnace and the steam-heating apparatus. Each of these has its own particular merits, but these are practically naught as aids to ventilation. Some of our largest school-rooms and churches, however, are splendidly equipped by reason of the hot-air furnace. The warm air is admitted by means of registers built in the floor. These are located a sufficient distance from the desks of the school children, so as not to cause any of

them to become overheated; because nothing is more dangerous than to stand or sit over a hot-air register on a chilly, wintry day. The windows are lowered from the top so as to allow the expired air a means of escape. The windows, long and with large panes of glass to insure plenty of light and sunshine, extend within a few feet of the floor. Between the windows additional small inlets for fresh air are also provided. This arrangement permits the fresh air to be properly heated at the time of its entrance into the room.

A school-room heated by a steam-heating apparatus possesses practically the same advantages, namely, the fresh air as it enters is properly heated and warmed, and a ready exit can also be provided for the air that has been breathed.

#### HEATING VERSUS VENTILATION.

There is more truth than poetry in the old adage, "Keep the feet warm and the head cool." School children cannot study properly if their feet are cold. Cold feet cause a rush of blood to the head, and are a frequent source of headaches in school children, in addition to the discomfort which they invariably produce. Parents should see to it that their children reach the school-room with their feet warm and dry, and teachers should make it a point to preserve this condition of affairs during the time spent in the school-room. The teacher can only do this by paying strict attention to ventilation and heating.

Doubtless it has already occurred to you that the old way of heating a school-room by means of stoves is not as sanitary as it ought to be. Unless proper provision be made, such a school-room cannot be properly and effectually ventilated. But it should be added that it is well-nigh impossible to heat our smaller school-houses, especially country school-houses, otherwise than by means of stoves. A redeeming feature is the fact that country school-houses, as a rule, are not over-large.

Country schools may be heated by stoves surrounded by sheet-iron drums, and ventilated with fresh air from without brought in near the bottom of the stove. I admit this would be a perplexing and difficult problem in most country school-houses, and scarcely at all practicable. But you must see the force of my argument. It is to provide for the requisite amount of fresh air properly warmed upon its entrance into the school-room.

The last-named feature calls forth another important desideratum in the ventilation of school-rooms. It is this: Avoid bringing in large quantities of air from without that has not been properly warmed, otherwise unpleasant chilling and injurious draughts will be the result.

#### OTHER DESIDERATA IN VENTILATION.

Any correct system of ventilation must take into account the source of the air supplied, the distribution, and the heating or cooling of the air when necessary. For school-rooms and the like there must be extreme care taken that the pupils have a full supply of properly warmed air and are not overcrowded.

The air supplied to school-houses should be taken from a point well above the level of the ground, where it is free from contamination and is constantly changing, and not from cellars or closed areas, where the atmosphere is stagnant and full of impurities. The conduits or pipes leading to the heating or ventilating apparatus should also be so arranged that they may be frequently and readily cleaned. It is well to have them covered with gratings to prevent objects being thrust into them, and in some cases it may even be advisable to filter the air through coarse cloth or fine wire-gauze to free it from dust and other impurities. This latter remark especially applies to school-houses located in manufacturing towns or cities.

The following are the two most difficult problems in the ventilation of school-rooms:

- 1. To secure a uniform distribution of pure air through the school-room. And,
- 2. Remove the impure air as fast as the pure air is supplied, thus preventing its undue mixing with the latter.

But "circumstances alter cases," and certain circumstances always make the question complicated. These are the size and number of inlets and outlets, the rate and direction of motion, and the forces acting to produce it must always be subject to constant change, and must thus constantly alter the result. In fact, it is practically impossible to devise a broad, general plan that will satisfy all conditions at all times. Doing the next best thing is in order, and this consists in selecting the one plan which will give the greatest efficiency and most satisfactory results under all ordinary circumstances.

The force of diffusion, the purifying action of winds, and the utilization of various simple mechanical devices will next be considered. The force of diffusion is the first main force of natural ventilation described above. This will always act so long as there is any communication between the exterior and the interior of the school-room, and hence no special attention need be given to it. For reasons already given, we cannot use the wind continually. But we should employ this great aid to natural ventilation whenever possible by opening the doors and windows of the school-room at recess time, during the noon respite and before and after school hours. The benefits which accrue thereby are incalculable, because of the great power which the wind has for sweeping out solid impurities and thoroughly changing the air.

As physical geography defines it, "wind is air in motion"; therefore, in cold weather currents from windows, etc., should be directed toward the ceiling so that they may be diffused and partially warmed before reaching the inmates of the school-room. This is especially important as regards the tender occupants of the primary department.

Numerous devices have been suggested for introducing unwarmed outdoor air without discomfort, or for diffusing it through the school-room. Among these may be mentioned perforated bricks or double-paned windows similar to those in use in Pullman cars, valves, screws, cowls or ventilators. A cheap and satisfactory temporary arrangement is to place a board about four inches wide and just as long as the width of the window-sash beneath the latter. Or, better still, have a light frame covered with fine netting or wire-gauze, four or five inches wide, made to fit above the upper sash. The fresh air from without can now enter freely between the upper and the lower sash, being reflected upward by the inner surface of the glass in the upper sash, and thus mixing with warm air before reaching the occupants of the school-room; while the frame at the top of the window becomes an outlet for the foul air, the interference of the netting or gauze preventing too rapid an outgo and consequent loss of heat. The Pullman automatic ventilator, now in use in various banks and other public buildings, is one of the best of the highpriced ventilators.

The crude method used by a friend of mine for ventilating his sleeping apartment could be utilized at certain seasons of the year for ventilating the school-room: Remove an upper pane of glass from one of the windows. This has reference to windows having panes of glass of small size.

But in a variable climate like our own, and in cold countries, the outdoor air must be warmed before it is permitted to enter the school-room. Special measures must be taken during a large part of the year to bring about this desideratum.

The third force of natural ventilation, viz., the movement of unequal weights of air, is our sheet-anchor in the ventilation of many school-rooms. In these instances we must provide other openings for the entrance and exit of the air than the windows and doors. Three considerations should be met:

- 1. There should be a practically constant movement of the air through the school-room in a given direction.
  - 2. We should be sure that the air is from a pure source. And,
  - 3. We should aim to get the utmost service from our appliances.

The selection of the best locations for inlets and outlets has aroused considerable discussion, and there is widespread difference of opinion on this phase of our subject. Rigid general rules cannot be laid down. In every case there are special exigencies to be met, as the conditions are necessarily different and so many factors are to be considered. Two aims should be ardently sought for:

- 1. To have the air well distributed through the school-room or school-rooms. And,
- 2. To have no direct draughts from the inlets either upon the occuppants or to the outlets.

It is infinitely better that the outlets should be located near the top of the school-room. This can be explained on the grounds that the heated and used air has a tendency to rise, and because, in unventilated school-rooms, the foulest air for sometime after its contamination will be found in the portions of the room nearest the ceiling. The products of combustion from lights, etc., will also practically all be in the upper strata of air. This latter feature is of slight importance with regard to school-rooms, as the sessions are almost invariably held in the day-time.

So much for the location of the outlets. The location of the inlets will next engross our attention. The location of the inlets should depend upon the temperature of the incoming air, that is, whether it be hot or cold. If the incoming air is cold, it should be admitted near the ceiling, if possible, so that it may diffuse and be partially warmed before reaching the inmates of the school-room. If the incoming air is warmed, it may come in near the floor or below the middle level of the school-room.

In a small school-room one inlet and one outlet may suffice; but, in the case of the larger school-rooms where more fresh air is required, it is better to have a number of smaller inlets and outlets than one large one of each, as the distribution is then more certain. The total area of the outlets and of the inlets may be the same, as the expansion of the air is scarcely great enough to require a difference. The outlets should all be on the same level; otherwise the highest one will be the one of greatest discharge, and often the only one, the others possibly acting as inlets and drawing air from an impure source. Variations of temperature and current take place from time to time; hence some arrangement should be provided for regulating the size of the openings of the inlets and outlets in order to meet the existing conditions.

If the school-room be too small or overcrowded, the problem of ventilation is rendered still more perplexing. Many more changes of air will be needed, and the velocity at the inlets will of necessity be increased. Uncomfortable draughts are the inevitable result. Imperfect diffusion of the air throughout the room is another feature of importance scarcely secondary to that of the creation of draughts. Even when the air is properly warmed, so common experience shows, it cannot be changed much oftener than three times an hour without discomfort to the occupants of the school-room; unless the ventilating apparatus be very perfect in its workings and of a most approved type. Owing to its expensiveness, the beau ideal of a ventilating apparatus is rarely found in an ordinary school-room.

Again, it must be remembered that the difficulty of securing equable heating and ventilation increases with the height of the school-room above a certain limit. Ten or twelve feet will usually be found to be the safe limit of height for the average school-room.

#### THE SMEAD SYSTEM OF VENTILATION.

Probably the best of the artificial ventilators is that known as the Smead system of ventilation. The Smead system of ventilation can be installed by any up-to-date sanitary plumber. In the Smead system the

used air is withdrawn from near the floor level and below the inlet openings, though not in too close proximity to them, since in this way a more thorough distribution of the incoming air and a greater dispersion of its contained heat are secured. The Smead system of ventilation and heating still further serves economy by carrying the foul air beneath the floor of the room from which it is taken, thus warming the floor with what heat the waste air yet contains and securing the utmost benefit and value from the fuel.

The Smead system of ventilation and heating has been used with satisfaction in many schools throughout the country. In this, the air after being warmed and brought into the school-rooms at a level a few feet above the floor, circulates through them and is finally withdrawn through registers at the floor level, whence it is carried underneath the floors to large outlet shafts in which a draught is constantly maintained. In this way a thorough diffusion and changing of the air in the school-rooms is secured, and, moreover, the floors are kept warm by the heat from the air which is passing beneath them, but which would otherwise be lost and wasted.

## AMOUNT OF FRESH AIR NEEDED.

Ordinarily we consider 3000 cubic feet of fresh air to be the average amount required per scholar per hour. Accepting this figure as a good working basis, the *cubic space* per pupil should be at least 1000 cubic feet. Reduced to cubic meters, this would be from 25 to 30 cubic meters per pupil. This figure is not excessive from a sanitary standpoint, although few school buildings meet the requirements here set down. About one-half the above figure is the amount of space usually allotted per pupil.

### AN IDEAL SCHOOL-ROOM.

Schools should be so constructed as to permit of ready heating and ventilation, cleaning, and keeping clean. In large schools the method of heating will usually be by furnace-heated air, although a better method would probably be by steam or hot-water pipes.

Natural ventilation will give better satisfaction than a complicated artificial system. Where windows and doors must be largely depended upon for ventilation, the Bury window ventilator will give satisfactory results unless the school-room is overcrowded.

The Bury ventilator, so-called after its originator, is the special ventilating arrangement which we most commonly observe in large offices and in public buildings. The Bury ventilator consists of a wooden block interposed between the bottom of the lower window sash and the window frame. The air passes into the room through the openings in the block. The separation of the upper and lower sashes, when the ventilator is in place, also adds to the efficiency of the ventilation, as the air passes in through the space so formed.

Opening the doors and windows when the pupils are out of doors—flushing the rooms with fresh air—is an excellent aid, and is even useful in cases where the most elaborate artificial system of ventilation is in use.

A model school-room, according to modern views, should be about 9 to 10 meters long, not over 7 meters wide, and 4 to  $4\frac{1}{2}$  meters high. Such a room could be easily lighted by windows on one side only, and readily heated and ventilated. In a room of this size forty pupils would be a proper number, although fifty could be accommodated. The initial air-space for each pupil would be 5.60 cubic meters if there were fifty pupils in the room, and 7 cubic meters if there were only forty. This would be slightly reduced by the allowance for the teacher. The window area should be not less than one-fifth of the floor area, otherwise the light will be deficient. It is better that school-rooms should face toward the north. The light entering from the north side of a building would be equable during a whole day.

#### CHEMISTRY OF RESPIRATION.

The average composition of air in its normal state is about as follows: Oxygen, 20.96 per cent by volume.

Nitrogen, 78 per cent.

Argon, 1 per cent.

Carbon dioxide, 0.004 per cent.

Watery vapor, varying in amount with the temperature and other conditions.

A trace of ammonia, and a variable amount of ozone, organic matter, sodium salts, etc.

Oxygen is the most important of the above constituents. It supports all animal life; oxidizes, destroys and renders harmless organic impurities, and, by oxygenating the blood and oxidizing the food for our tissues,

gives us heat and energy, the vital source of all our thoughts and actions. It is oxygen that puts iron into our blood. Surely, "the blood is the life." The "pale student," poring over his books, has become proverbial.

Air that has been breathed, or expired air, is deficient in oxygen and contains an excessive amount of carbon dioxide, watery vapor and organic matter, the latter being by far the most harmful part of animal exhalations.

## DISEASES CAUSED BY DEFECTIVE VENTILATION.

It has been stated that 40 per cent of the diseases of winter are due to improperly ventilated houses and school-rooms. Pupils habitually living in such an atmosphere are almost uniformly languid, pallid and anemic, subject to headaches, nausea and loss of appetite, and often to skin eruptions and disorders, and are undoubtedly markedly predisposed to consumption, pneumonia, bronchitis, scrofula, rickets, etc. Moreover, such an atmosphere apparently favors the spread of the various infectious diseases, such as diptheria, scarlet fever, measles, mumps, chicken-pox, influenza, etc.

Parents often wonder why their children are stupid and drowsy while at school. They do not progress favorably in their studies. Defective ventilation is often a rational explanation. Then it is that much study becomes "a weariness of the flesh."

Defective ventilation often causes people to go to sleep while attending church service, much to the annoyance of the earnest, well-meaning minister.

### GUARD AGAINST MOUTH-BREATHING.

Now that you have provided pure air for your pupils, another duty awaits you. It is this: See to it that your pupils breathe through their nose and not through their mouth. Man is a bundle of habits. Eighty per cent of mouth-breathing is due to force of habit; 20 per cent is due to adenoids, enlarged tonsils, or both. These latter need the services of a physician.

Captain Catlin, an American artist who spent eight years (1832-1839) among the Indian tribes of the Upper Missouri, gives us another clue to the remarkable vigor and healthfulness of the Indian, and his compara-

tive freedom from disease, especially throat and lung troubles. It is this: One of the rules of an Indian's life is to breathe through his nose, not through his mouth. In this respect, civilized nations can learn a most valuable lesson from the wild Indian of romantic history.

Captain Catlin wrote several books. One of them is a little volume entitled, "Shut Your Mouth and Save Your Life." On page 31 he says:

Besides this frequent and most fatal of all diseases—consumption—bronchitis, quinsy, croup, asthma, and other diseases of the respiratory organs, as well as dyspepsia, gout of the stomach, rickets, diarrhea, diseases of the liver, the heart, the spine and the whole of the nervous system, from the brain to the toes, may chiefly be attributed to this deadly and unnatural habit; and any physician can easily explain the manner in which these various parts of the system are thus affected by the derangement of the natural functions of the machine that gives them life and motion.

The proverb, as old and unchangeable as their hills amongst the North American Indians, "My son, if you would be wise, open first your eyes, your ears next, and last of all your mouth, that your words may be words of wisdom, and give no advantage to thine adversary," might be adopted with good effect in civilized life.

And if I were to endeavor to bequeath to posterity the most important motto which human language can convey, it should be in three words—

SHUT YOUR MOUTH.

#### CONCLUDING REMARKS.

Already you have been reminded of the sacredness of your calling. The minds and bodies of our children—our country's most valuable asset—are in your hands. I beseech you to watch over them carefully and with reverent devotion. Remember the Emersonian dictum: "The first wealth is health." The significance of the old adage, "A sound mind in a sound body," is also as true to-day as it was generations ago when first uttered.

In cultivating the minds of your pupils, do not forget to impart instruction concerning the care of their bodies. "Train up a child in the way he should go, and when he gets old he will not depart from it." Childhood impressions are the most lasting. In childhood and early youth the mind, as well as the body, is more plastic and more susceptible to good or evil influences. Habits of right thinking and right living formed during the tender, ne'er-to-be-forgotten years of school-life wield a powerful influence in shaping one's destiny in after life. We are the architects of our own fortunes. Children who are compelled to sit 5 to 6 hours a day in a poorly-ventilated school-room (if ventilated at all) are

contesting an unequal contest. A tender, growing plant would not thrive long under similar unhygienic conditions. Your potted plants—geraniums, begonias, oleanders, ferns, palms, etc.—would wither and die if exposed to the vitiated atmosphere of many unventilated school-rooms.

It is well to have a few green plants in the school-room. Their condition is a pretty accurate index to the purity of the atmosphere. In a room where plants grow and wax strong, children can also dwell with impunity. During the process of respiration, animate beings take in oxygen and throw off carbon dioxide; plants absorb carbon dioxide and liberate oxygen, by the process which you who are teachers of botany term photo-synthesis.

I desire to thank Mr. Melvin for his kind invitation to be present this afternoon to address this meeting. I thank you, members of the teaching profession, for your kind attention. I am well aware that the pathway of the school teacher is not always strewn with roses. Doubtless some of you have met with such scenes as Charles Dickens describes in his "Death of Little Nell," in which he says, "Towards night, the schoolmaster walked over to the cottage where his little friend lay sick." On the other hand, perhaps some of you have met with a happy experience similar to that of the school mistress mentioned by Oliver Wendell Holmes in his "Autocrat of the Breakfast Table." Dr. Holmes, the apostle of sunshine and cheerfulness, he who was "seventy years young," tells us of the charming school mistress who decided to "take the long road" with her gentleman friend.

My first school teacher, my teacher of 31 years ago, Mr. John Lewis Lutz, is still living in honorable retirement near Middletown, Frederick County, Maryland. He is 73 years of age.

In conclusion, I wish to read a short poem by Mrs. Margaret Sangster, entitled, "The Old Schoolhouse." The poem is this:

"Set on a rounding hill-top
And weather-stained and gray,
The little mountain schoolhouse
Looks down on the lonesome way.
No other dwelling is near it,
'Tis perched up there by itself
Like some old forgotten chapel
High on a rocky shelf.

"In at the cobwebbed windows
I peered, and seemed to see
The face of a sweet girl teacher
Smiling back at me.
There was her desk in the middle,
With benches grouped anear,
Which fancy peopled with children—
Grown up this many a year.

"Rosy and sturdy children
Trudging there, rain or shine,
Eager to be in their places
On the very stroke of nine.
Their dinners packed in baskets—
Turnover, pie and cake—
The homely, toothsome dainties
Old-fashioned mothers could make.

"Where did the little ones come from?
Fields green with aftermath
Sleep in the autumn sunshine,
And a narrow tangled path
Creeping through brier and brushwood
Leads down the familiar way;
But where did the children come from
To this school of yesterday?

"Oh, brown and freckled laddie,
And lass of the apple cheek,
The homes that sent you hither
Are few and far to seek.
But you climbed these steeps like squirrels
That leap from bough to bough
Nor cared for cloud or tempest,
Nor minded the deep, soft snow.

"Blithe of heart and of footstep
You merrily took the road,
Life yet had brought no shadows,
Care yet had heaped no load.
And safe beneath lowly roof-trees
You said your prayers at night,
And glad as the birds in the orchard
Rose up with the morning light.

"Gone is the fair young teacher;
The scholars come no more
With shout and song to greet her,
As once, at the swinging door.
There are gray-haired men and women
Who belonged to that childish band,
With troops of their own around them
In this sunny mountain land.

"The old school stands deserted,
Alone on the hill by itself,
Much like an outworn chapel
That clings to a rocky shelf.
And the sentinel pines around it
In solemn beauty keep
Their watch from the flush of the dawning
Till the grand hills fall asleep."

# A NEW METHOD OF OBTAINING RECTANGULAR FLAPS FOR TRANSFERENCE WITH A PEDICLE.\*

BY W. WAYNE BABCOCK, M. D.,

Professor of Surgery in the Medical Department of the Temple College, and Surgeon-in-Chief to the Samaritan Hospital, Philadelphia.

It is at times desirable to utilize a rather long rectangular flap in plastic surgery, and conditions arise in which the integrity of the flap is jeopardized unless it has a pedicle of rather ample size. If the pedicle be formed by one extremity of a long rectangular flap, the life of the terminal portion of the transplanted skin is apt to be imperiled by its distance from the source of blood-supply. Upon the other hand, if one of the long sides of the rectangle be used as the base of attachment, the length of the attached surface usually interferes with the manipulation of the flap, by greatly reducing its mobility and interfering with its accurate coaptation to the surface to be grafted.

These facts were impressed upon me by the condition resulting in a patient of mine after the middle two-thirds of the anterior surface of the tibia had been excised for an extremely chronic osteitis and periositis. In this case the veins of the leg were varicose, and the skin over the affected tibia atrophic and largely cicatricial, conditions that resulted in the prompt death and sloughing of the flaps placed over the portion of excised bone. Thus there resulted an area of denuded bone about seven inches in length and about one or one and a half inches in breadth, edged by a sloughing line of atrophic and varicose skin (Fig. 1). In this case, in view of the unhealthy condition of the neighboring skin, an attempt to secure a covering for the denuded bone, by displacement from adjacent soft tissues, did not seem to be feasible, and there was every probability that a flap transplanted from another portion of the body

<sup>\*</sup> Reprinted from Medicine, E. G. Swift, Publisher, June, 1905.

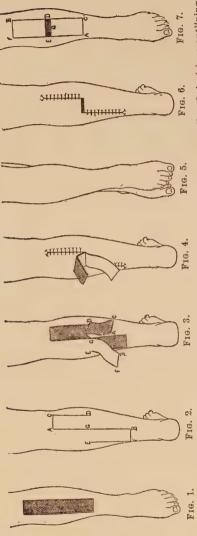
without a pedicle would promptly die. The method to be described was, therefore, devised and adopted, and it enabled the securing of good apposition with a fair pedicle, and moreover left a nearly linear scar upon the surface from which the flap was removed.

While in this case the method was employed to convey skin flaps from one limb to another, it is equally applicable to the transference of rectangular flaps between any parts of the body that may be brought in convenient proximity, and has the great advantage of leaving no uncovered surface upon the part of the body from which the flaps are removed.

The method consists in forming two rectangular flaps, having a width at least one-third wider than the part to be covered, and a combined length about one-third greater than the greatest diameter of surface to be covered. These are formed in the following manner:

A straight incision (Fig. 2, a b) is made equal to the combined lengths of the flaps to be raised. Parallel to this first incision and at a distance equal to the width of each flap to be formed, two secondary incisions, one upon either side of the original incision, are made. Upon one side a second incision (c d) is placed opposite the upper half of the first incision, while the third incision (e f) is made upon the other side of the first incision and parallel to its remaining half. By uniting the distal ends of the last two incisions with those of the first, two flaps (g a c d and g b f e) are formed, which are then raised, leaving two lines of parallel and equidistant wound edges (g a and d c and g b and f e). These are then united in a linear manner, the bases of the flaps being slid by each other until they become exactly opposite (g d being superimposed upon eg). (Fig. 4.) There now remain two linear incisions, at the proximal ends of which are attached the bases of the two flaps with raw surfaces outermost ready for attachment to the surface to be covered. These surfaces are prepared for grafting in the usual manner, and the limb with the grafts attached is superimposed upon the surface to be covered (Fig. 5). The grafts are then fastened to their new position by interrupted or continuous sutures, and the folds at the pedicle of the grafts protected from angulation and pressure by properly applied padding of sterile gauze.

After completing the conventional antiseptic dressing of the wound surface, the two opposite portions of the body are immovably united and



method of superimposing right leg upon left in order to place grafts in position. Fig. 6, cicatrix left upon right leg after the secondary division of pedicles of grafts. Fig. 7, grafted leg showing adhering grafts, after approximated by sliding, with immediate suture of denuded surfaces from which grafts were taken. Fig. 5, Fig. 2, incisions outlining Fig. 4, long axes of grafts Fig. 1, denuded surface upon left leg prepared for the reception of grafts. grafts to be taken from the right leg. Fig. 3, grafts dissected back to pedicles. division of pedicles.

fixed in position by some retentive dressing, such as one of plaster Paris. At the end of from five to ten days, when the grafts have acquired a sufficient circulation from their new bed, the two pedicles are divided and the limbs separated, leaving a short transverse incision (e d) upon each limb (Figs. 6 and 7).

It is important that the retentive dressing afford absolute support, so that there be no undue pressure between the opposing surfaces, and that adequate fixation, absolutely preventing any displacement, be provided. In the above mentioned case the plaster dressing was defective, and permitted motion between the opposite surfaces. The upper layers of the graft sloughed, but there remained a fairly thick granular surface, almost covering the entire surface of the denuded bone, which was readily covered by small Thiersch grafts. The procedure is, of course, applicable within limits. The greater the breadth and the shorter the length of the grafts required, the greater the chances of success.

The method may be used not only for securing transference of tissue from one leg to another, but from nearly any portion of the body which may be brought into continuous relation to another. Thus it may be used to carry skin from the arm to the face, from the chest or abdomen to the head or arm, or *vice versa*, or from one thigh to another.

Finally it is to be observed that grafts of this character are only to be used in rather exceptional cases, the method of transference without a pedicle by the Thiersch or Reverdin methods being generally more applicable, and giving far less inconvenience to the patient.

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CHAS. EMIL BRACK, M. D., Business Manager, 500 E. Twentieth St.

## THE JOURNAL

### OF THE ALUMNI ASSOCIATION

OF THE

## COLLEGE OF PHYSICIANS AND SURGEONS, BALTIMORE.

### A PHYSICIAN AS A BUSINESS MAN.

We print in this number of the JOURNAL a short article by Dr. Cummings, of Williamsport, Pa. Need business qualities interfere with the successful practice of medicine? This subject is an old one and has been discussed from time to time in the various medical journals and before the various medical societies, and the result will always be the same until human nature changes. Some physicians will conduct their practice with an eye to their own welfare as well as that of their patients, whilst others will always neglect their own interests for the real or fancied benefits of their clientele, in the long run to do less for them than the former socalled hard-hearted physician. Every physician in practice owes it to himself to make all those who are able to pay do so, but there is no need to charge unnecessarily high fees. A modest living is all that any physician can ever hope to earn. The reduction of charity cases is usually easily accomplished by either devoting a certain amount of time to them or seeing as many as possible in the hospital or in clinics. As a matter of actual fact it is not looking after charity patients that impoverishes the physician. Every one of us in the practice of medicine has many such and is only too glad to minister to their needs. It is the caring for the dead-beat and the patient who willfully deceives the physician in regard to his income, and moves leaving no address, that makes the difference between success and failure. We know of families who boast that they have never paid a physician and yet they have had for all the members of their family, for many years, the best medical attention that a large city affords. This would not happen if physicians were a little bit more careful about collecting their bills, which includes: First, the keeping of accurate accounts; second, the charging of fair fees; third, the regular rendering of bills at not too long intervals and the following up promptly of all people who do not pay using, if necessary, the services of a collector or an attorney. Some people are offended by having a collector come, but the man who is offended because he does not pay his just debts within a reasonable time is the man whom it is better to allow to go somewhere else and once having had the sad experience of having a patient neglect to pay his bill for several years, the physician has a right to demand cash or refuse treatment, if need be, apart from an emergency or when the dictates of humanity require that the patient be cared for. If every physician would resolve once a month to see that those who ought to pay and can pay do pay, there would be a great many happier homes among the profession and fewer disappointed old physicians than there are at present.

### THE AMERICAN THERAPEUTIC SOCIETY PRIZES.

On recommendation of the Council of the American Therapeutic Society, at the annual meeting of the Society held in Montreal, Canada, June 1, 1912, it was voted that prizes of two hundred and fifty (\$250.00), one hundred and fifty (\$150.00) and one hundred dollars (\$100.00) be awarded to the best reports on subjects relating to Therapeutics, on the following conditions:

- 1. The competition is to be limited to qualified physicians in the United States and Canada.
- 2. The subject of the competition is to be limited to a substance or preparation which is official in the United States Pharmacopoeia.
- 3. The research may be either wholly laboratory or clinical, or laboratory and clinical combined, and must be conducted in a public institution.
- 4. The reports must be (a) designed by a distinctive word or motto, and (b) must be accompanied by a sealed envelope marked with the said word or motto, and containing the name and address of the competitor and of the laboratories or hospitals in which the research was conducted.
- (c) The report and protocol must be typewritten. (d) These must be in the hands of the Chairman of the Committee before April 1, 1913.

- 5. The reports and protocols are to be judged by a Committee consisting of the three Vice-Presidents of the Society, who shall decide which are the best reports as showing valuable therapeutic research, and shall return their decision, together with all the papers submitted to them, to the Chairman of the Council of the Society before May 1, 1913.
- 6. The Chairman of the Council shall then return the unsuccessful reports to their authors, and shall notify the successful author or authors.
- 7. The successful report or reports shall be read by the author, or a designated member of the Society, on the first day of the meeting of the Society, immediately after the President's address.
- 8. All matters connected with the competition shall be considered as absolutely confidential by the Chairman of the Council and the Judges, except as to the successful competitors.
- 9. The Vice-Presidents as judges may fail to award any prize if the report or reports entered in the contest are not found to be of a sufficiently high standard.
- 10. In case any Vice-President shall fail to act, the President of the Society shall designate a substitute.

REYNOLD WEBB WILCOX, THOMAS L. SATTERTHWAITE, SPENCER L. DAWES,

Committee.

### CLASS REUNIONS.

Many members of the class of 1903 are very enthusiastic over the prospects of a large reunion in June. Dr. Edgar Friedenwald, A. Ferdinand Ries and Dr. Joseph I. France are a committee of arrangements. Any communication regarding the meeting may be addressed to them.

Dr. T. C. Harter, '81, 208 Main St. Bloomburg, Pa., is interested in a reunion of '80 and '81. Members of these classes will communicate with Dr. Harter.

### HOSPITAL POSITIONS VACANT.

Owing to unavoidable changes in the hospital staff of the Mercy Hospital, there are at present several vacancies which will be filled in the near future. Any of our alumni who desire to finish out the year in the

hospital will find this an excellent opportunity to do clinical work, and to get in touch with the various clinical methods. Applications should be sent to Dr. A. C. Gillis, Mercy Hospital, Baltimore, Md.

The following names are on our missing list and we would request our alumni to supply any information they may have of their former classmates:

CLASS OF '72.
Garnett, Alfred H.
Penrod, Hiram J.
Price Jno. F.

CLASS OF '80.
Blair, G. A.
Brown J. Marion.
Doud, Edw.
Hamilton, A. T.
Knapp, R. S.
Knox, R. S.
Lightner, Theo.
Orahburn, H. K.
Owen, W. P.

Shutt, Jno. F. CLASS OF '81. Bennett, A. B. Bitting, L. L. Brashaw, W. G. Byram, Jno. Christian, T. H. Eggert, Geo. L. C. Estill, Harry B. Fauber, T. Hunter. Froehling, Henry. Gillespie, W. H. Goodman, F. S. Hackney, T. J. Jackson, T. J. Johnston Wm. A. Jolley, B. B. Keitt, E. Geo. Lafferty, J. H. Long, Jas. E.

Lucas, J. B.

Moore, B. F.

CLASS OF '81-Cont'd. Pair, A. D. Parvin, How. M. Pass. A. D. Price, H. M. Robinson, Remus. Scott, Warren F. Small, H. D. Smith B. Hall. Sydnor, C. W. Turner, Benj. A. Unruh, M. L. Weston, E. E. Vosburgh, A. J. Wood, O. J. Wood, C. D.

CLASS OF '84.
Cooper, A. T.
Johnson, L. H.
Kelly, Carl M.
Murray, Hosea P.
Robinson, O. P.
Robinson, F. E.
Showalter, J. B.
Webb, M. W.
Webb, N. B.

CLASS OF '89.

Barker, T. C.
Chagnon, L. A.
Mosher, Jas. D.
Nash, LeRoy T.
Stevens, Wm. H.
Taylor, Anthony Wm.
Varn, Aaron Crook.
Warden, Frank R.

CLASS OF '89—Cont'd.
Wilson, E. L.
Wright, Clinton H.
Young, W. D.

CLASS OF '93.

Beckwith, Dan. G.
Bruce, Chas. W.
Campbell, J. I.
Cassady, Harry V.
Cousin, Chas. C.
Delgadillo, C. A.
Downes, Morton E.
Evanson, Jas. J.
Limerick, Oliver V.
Mulhane, T. L.
Phleeger, Jos. W.
Shaffner, L. Rich.
Stone, Wm. P.
Wolff, A. Curtin.

CLASS OF '03.
Belcher, H. J. B.
Buschal, Robt. F.
Merrick, Geo. E.
Munro, Henry W.
Wilmot, H. O.

CLASS OF '04.

Aursleff, C.

Hennessy, Jas. F.

Hoskins, Albert J.

King, C. A.

MacNeil, B. C.

MacDonald, T. D.

Miller, Harvey.

Sage, Thos.

CLASS OF '05.

Brinker, Sam. P.
Crosby, Theo. S.
Hess, J. M.
Martin, F. E.
Schwab, Harvey M.
Smith, X. Y.
Thomas, G. N.
Thomas, Geo. R.
Weber, Clarence.

CLASS OF '06.
Miller, J. D.
Umbel, I. W.
Lemke, Geo. F.

CLASS OF '07.

Mack, Geo. L. Robinson, W. H. Thomas, E. M. Van Kirk, A. W. Walsh, Jos. W.

CLASS OF '08.
Brown, R. J.
Leahy, Jno. T.
Miller, Wm. M.

CLASS OF '09. Weller, J. H.

CLASS OF '10.

Kahle, Gail W. Giorgessi, Joseph.

Buquoi, Jno. F., '98. Fultz, Benno Hugh, '01. Hamilton, Jas. M., '74. Hanley, Jno. J., '94. Hartt, Whitfield, '89. Henderson, Wm. L., '95. Holmes, A. M., '85. Jarvis, G. L. B., '92. McAlpin, Wm., '86. Sims, Edgar W., '83.

### Personal Potes.

Dr. Chas. F. Blake, '93, has had conferred upon him by the University of Ohio an honorary degree of Master of Arts. Loyola College has conferred upon Dr. Emil Novak the degree of Bachelor of Arts.

Dr. Frank L. Benson, '10, of Punxsutawney, Pa., was married to Miss Julia Kennedy, of Jersey City, August 14, 1912.

DR. J. M. Scanland has been elected president of the Montana State Medical Association.

### Dhituary.

George Washington Simpson, '73, a member of the American Medical Association died at his home in Baltimore, August 18, from heart disease, aged 71. Dr. Simpson was rather a remarkable character and was a native of Baltimore from Scotch Irish descent. He was educated in the public schools of Baltimore and of the Eastern Shore and at a very early age began to study theology. Subsequently he determined to take a course in medicine and soon after his marriage he entered the college and a short time after he was graduated, he was appointed chaplain in the army by President Grant. He served at various army posts including Fort Sill in the Indian Territory, Fort Union in New Mexico,

Fort McPherson in Nebraska, Fort Robinson in the same state and Fort Laramie, Fort McKinney and Fort Brazer, Wyoming.

About 20 years ago he retired from the army service and returned to Baltimore and began the practice of medicine. For 14 years he was physician in the Johns Hopkins Colored Asylum and in addition to his medical duties he looked after the religious services. He was among the best known of practitioners in Baltimore.

DR. CHARLES F. HOPKINS, '84; a member of the American Medical Association; for twenty years a practitioner and once mayor of Chinook, Mont.; local surgeon of the Great Northern Railway; health officer of Chouteau County; died at his home in Long Beach, Cal., August 18, from cerebral hemorrhage, aged 53.

Dr. Edward Joseph Shanahan, '96; a member of the American Medical Association; at one time city physician of Taunton, Mass.; died at his home in that city, June 27, from facial erysipelas, aged about 50.

Dr. Albert Matson Belden, '88; formerly a member of the American Medical Association; first president of the Hampshire County Anti-Tuberculesis Association; superintendent of the Norwood Sanitarium, Northampton, Mass.; died at his home in that city, August 5, from pernicious anemia, aged 46.

Dr. William Horace Johnson, '79; a member of the Medical Society of the State of Pennsylvania; died at his home in Dudley, August 17, aged 70.

Dr. Charles O. Cooley, '777; a member of the American Medical Association and Minnesota Valley Medical Association; one of the best-known practitioners of southern Minnesota; died at his home in Medelia, Minn., June 13, aged 61.

Dr. Charles Henry Brueckner, '01; died at his home in Newark, N. J., June 24, from peritonitis following a rupture of the gall-bladder, aged 36.

### Correspondence.

Dear Dr. Brack.—I received the JOURNAL of the Alumni Association a day or so ago and return thanks for the same. I will remit in a few days. I am located at Anawalt, W. Va. Passed the West Virginia Board

and received my certificate. My best paper was on your branch and surgery, a full mark upon each of these subjects. The obstetrics and gynecology examination was mostly from the subjects you taught after Xmas. In fact the whole examination was covered by your lectures.

Yours sincerely,

P. C. SPANGLER.

SEDRO-WOOLLEY, WASH., August 19, 1912.

Dr. Chas. E. Brack, 500 E. 20th St. Baltimore, Md.

Dear Doctor Brack.—I am enclosing M. O. of \$1.00 for the JOURNAL. Thank you for sending it as it is like the visit of an old friend. I was much interested in reading Dr. Gardner's address to the nurses, as it showed the great work done by the faculty and sisters in building the college and hospital to the present state of efficiency. I was also glad that we will have an opportunity to have Dr. Gardner's practical teaching methods in our library. I am now operating a 25-bed hospital here, and if you know of any graduate nurses who intend coming to the Coast, I would be glad to communicate with them.

I hope to visit Baltimore next year and renew acquaintances with old friends. In the meantime please give my regards and best wishes to those remaining gentlemen of the faculty of whose teaching and many kindnesses I have the happiest recollection.

With best wishes to yourself, I am sincerely yours,

W. A. Dorsey.

## SOME VALUABLE PRODUCTS FOR THE TREATMENT OF DISEASES OF BACTERIAL ORIGIN.

Since the advent of diphtheria antitoxin it is doubtful if any new remedial agent has elicited greater interest than is now being manifested in the bacterial derivatives known as Phylacogens. These products were originated by Dr. A. F. Schafer, of California, the method of preparation and technique of application being first presented to the San Joaquin Medical Society in Fresno. To the uninitiated it may be said that the term Phylacogen (pronounced phy-LAC-o-gen) means "phylaxin producer," being derived from two Greek words signifying "a guard" and "to produce." The Phylacogens are sterile aqueous solutions of metabolic substances generated by bacteria grown in artificial media. They are produced from a large variety of pathogenic bacteria, such as the several staphylococci, streptococcus pyogenes, bacillus pyo-

cyaneus, diplococcus pneumoniae, bacillus typhosus, bacillus coli communis, streptococcus rheumaticus, streptococcus erysipelatis, etc.

Four Phylacogens are now offered to the medical profession: Mixed Infection Phylacogen (used in the treatment of bacterial diseases of unknown etiology), Rheumatism Phylacogen, Erysipelas Phylacogen, and Gonorrhea Phylacogen. They have been thoroughly tested clinically and are said to be producing excellent results in the treatment of the various pathological conditions in which they are indicated. They are administered hypodermically—subcutaneously or intravenously—preferably by the former method, the latter being advised only in cases in which a quick result is demanded. They are supplied in hermetically sealed glass vials of 10 cc. capacity.

The Phylacogens are prepared and marketed by Parke, Davis & Co., who have recently issued a 24-page pamphlet which describes them in detail—the process of manufacture, therapeutic indications, dosage, methods of administration—everything, in fact, that need to be known by the man who desires to use Phylacogens. Every physician in general practice, every practitioner who desires to keep abreast of the latest advances in bacterial therapy, should have a copy of this valuable booklet. Write to Parke, Davis & Co., at their general offices in Detroit, Mich., ask for the "Phylacogen pamphlet," and mention this journal.

#### THE CERTIFICATION OF PHARMACISTS.

DEAR DOCTOR.—Certain New York physicians and pharmacists have appointed a joint committee which is to thoroughly investigate New York pharmacies and certify to the worth of those that meet reasonable modern requirements in stock, in equipment and in practice.

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Indicated in the treatment of acute and chronic articular rheumatism not due to gonorrheal infection.

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### WRITE FOR DESCRIPTIVE LITERATURE.

\*The name Phylacogen (pronounced phy-lac'-o-gen) distinguishes the modified bacterial derivatives manufactured by Parke, Davis & Co. according to the process of Dr. A. F. Schafer.

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S. GRIFFITH DAVIS, M. D.,

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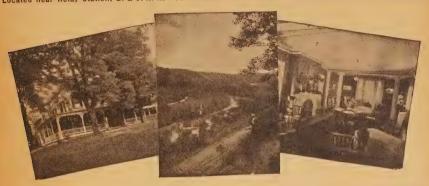


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## COLLEGE OF PHYSICIANS AND SURGEONS,

BALTIMORE.

## THE GASTRO-INTESTINAL DISTURBANCES OBSERVED IN PERNICIOUS ANEMIA.\*

BY JULIUS FRIEDENWALD, M. D.,

Professor of Gastro-Enterology, College of Physicians and Surgeons, Baltimore, Maryland.

The relation existing between pernicious anemia and various gastric affections has been a matter of great interest for many years. As early as 1860 Austin Flint called attention to the possible dependence of certain cases of pernicious anemia upon certain degenerative changes in the gastric mucosa. In 1865 Samuel Fenwick 2 published a memoir on "Morbid Changes in the Stomach and Intestinal Villi Present in Persons Who Have Died of Cancer," in which he observed the disappearance of the cells in the gastric tubules, granular and fatty degeneration and atrophy, and an increased formation of connective tissue with a marked thinning of the mucous membrane, and with loss of flesh. Especially did this condition occur in persons dying with cancer of the breast. He explained the anemia accompanying this disease as possibly due to the changes in the gastric tubules of the stomach. In 1877 Fenwick are ported four cases of pernicious anemia in which atrophy of the gastric tubules was observed. Later Nolen 'reported two cases of a similar condition; Quincke, one case; Nothnagel, one case; Brabazon, one case; Henry and Osler, one case, and Kinnicutt, two cases.

The opinion was held by these observers "that a primary atrophy of the gastric mucous membrane occurs and that in this lesion is to be found an explanation of certain cases of pernicious anemia." It is evident

<sup>\*</sup>Presented at the meeting of the American Gastro-Enterological Association at Atlantic City, June 5, 1912.

why this conclusion was reached. The entire degeneration of the glandular elements of the stomach, together with the loss of secretion, appeared sufficient to explain the condition of the blood. It was noted, however, that an entire absence of gastric secretion could exist for a long period of time without impairing the general health of the patient. It is, therefore, impossible to conclude that gastric atrophy causes pernicious anemia, and the two conditions must be classified as a result of a common cause; the cause which produces the hemolysis is also responsible for the atrophy of the gastric mucosa. Grawitz 10 has recently advocated the gastrointestinal theory as the cause of pernicious anemia, believing this condition to be due to an intoxication. He is inclined to lay great stress upon the achylia gastrica which is so commonly present in this affection. The objection to this theory is founded on the fact that achylia may be present for years without producing anemia; it is frequently present in other conditions, for instance, in malignant affections, or as a result of intestinal parasitic infections. Oestreich and Strauss" call attention to the histologic change observed in the mucous membrane of the stomach and intestine, occurring with much constancy in pernicious anemia, to which they attach much importance. The changes consist mainly of an atrophy of the glandular structures, and an accumulation of leucocytes in the submucosa. The accumulations of leucocytes they believe are similar to the leucocytic deposits occurring in other parts of the body in blood diseases. Notwithstanding the fact that the histologic changes show an apparent relation existing between the gastro-intestinal tract and the blood disease, they could not demonstrate a destruction of the blood by a poison generated by ordinary putrefaction in the intestine.

From the experiments of Strauss it is evident that neither ordinary nor artificial constipation is capable of producing the symptoms of pernicious anemia. The hemolytic agent, therefore, which produces the destruction of the blood cells in anemia must depend upon some special change not present in ordinary putrefaction. Tixier <sup>12</sup> describes the relations existing between gastro-intestinal disturbances and anemia and points to the slight alteration found in the gastro-intestinal canal in patients dying from anemia associated with intestinal conditions. He maintains that the blood changes in these cases must be explained by the formation in the intestine of a poison having both the power of

destroying the red corpuscles and that of stimulating the blood forming organs. The latter power is at times exhausted while the hemolytic power is still active. Moffitt <sup>13</sup> has recently suggested a protozoan infection as the cause of pernicious anemia; however, sufficient evidence is not yet available upon which to base such a conclusion.

The gastric secretion has been studied in pernicious anemia by a number of observers; H. H. Strauss <sup>14</sup> found free hydrochloric acid present but twice in a study of eight cases; and in 20 cases of Rosenquist, four cases of Moracewski, and in eight cases of Strauss free hydrochloric acid could be detected in but 16 per cent of the cases. Blocq <sup>15</sup> observed that in the stage of improvement in pernicious anemia there is an increase of free hydrochloric acid; while Schumann <sup>16</sup> found an absence of this acid even when patients had apparently recovered from the disease for over two years.

In a study of 24 cases of pernicious anemia, Stockton observed that 18 were affected with gastric disturbances; while six were free of such disturbances, 10 were constipated, eight had diarrhea, and in six there was an irregularity of the bowels. In 11 instances the liver was enlarged; in 13 it was not; nine cases showed a dilatation of the stomach. In 13 instances there was an absence of gastric digestion, in eight the gastric digestion was diminished, and in three it was fairly good. Five cases showed evidence of gastric catarrh. In six instances there was an absence of acid in the gastric contents, while the average of the total acidity varied around 10. In three cases free hydrochloric acid was present in traces; in all others it was absent.

Austin <sup>18</sup> found an absence of free hydrochloric acid, and of the ferments in his cases, while the gastric motility was diminished in most instances. He also noted an increase of urobilin in the urine and of stercobilin in the feces; occult blood was also observed in the feces. Of the 79 cases observed by Cabot, <sup>10</sup> only one presented hydrochloric acid in the stomach contents in any considerable quantity.

Our own observations extend over a series of 58 cases of pernicious anemia, in all of which gastro-intestinal symptoms were noted. Of the 58 cases there were 49 males and nine females, the ages ranging between thirty and sixty-two years. In all of these cases complete blood examinations had been made, and only those have been included in this report

TABLE ILLUSTRATING THE GASTRO-INVESTINAL SYMPTOMS OF THE RETY-EIGHT											
					ERNICIOUS			1	Per-		
				The state of the s				Total	cent-		
No. Name	. Age	. Sex	. Anorexia.	Nausea.	Vomiting.	Indi- gestion.	Bowels.	Acid-	age Free HCl.		
1 T.F.	51	$\mathbf{M}$	Present	Present	Brosolit	Absent	Diarrhea .	Sty.	0		
2 E.R.	47	M	Absent	Absent	Absent	Sygsent	Constinuted DM rhea	X	0		
3 K.K. 4 P.G.	38 60	M M	Present Present	Present Absent	Absent Absent	Present	Constipated	11	0		
5 T.N.	45	M	Present	Present	Present	Present	Irregular	8	0		
6 F.C.	42	$\mathbf{M}$	Absent	Absent	Absent	Present	Diarrhea	9	ő		
7 B.J. 8 T.M.	62 57	M M	Present	Present	Present	Present	Irregular	33	.02		
9 S.K.	42	M	Absent Present	Absent Present	Absent Absent	Present Present	Constipated Irregular	14 13	0		
10 D.V.	59	M	Absent	Absent	Absent	Absent	Constipated	56	.14		
11 L.J.	60	M	Present	Present	Present	Present	Irregular	9	0		
12 B.W. 13 P.S.	58 46	M M	Absent Absent	Absent	Absent	Absent	Diarrhea	8	0		
14 G.M.	39	F	Absent	Absent Absent	Absent Absent	Present Absent	Constipated Constipated	22	.02		
15 H.B.	47	$\tilde{\mathbf{M}}$	Present	Present	Present	Absent	Constipated	32	.11		
16 S.S.	56	M	Present	Absent	Absent	Absent	Constipated	12	0		
17 T.J. 18 M.L.	59 43	M M	Absent	Absent	Absent	Present	Constipated	14	0		
19 S.A.	59	M	Present Absent	Present Absent	Present Absent	Present Present	Constipated Constipated	8	0		
20 J.P.	33	F	Present	Present	Present	Present	Constipated	26	.03		
21 P.S.	49	M	Absent	Absent	Absent	Present	Diarrhea	9	0		
22 C.M. 23 L.K.	51	M	Present	Present	Absent	Present	Diarrhea	34	.05		
23 L.K. 24 F.E.	50 58	M M	Present Absent	Absent Absent	Absent Absent	Absent Present	Constipated Diarrhea	10	0		
25 H.B.	42	M	Present	Present	Present	Present	Irregular	8	0		
26 F.C.	37	M	Absent	Absent	Absent	Absent	Constipated	_			
27 E.M. 28 T.B.	44	M	Present	Present	Present	Present	Irregular	35	.03		
28 T.B. 29 F.N.	$\frac{36}{52}$	$_{ m M}^{ m F}$	Absent Present	Absent Present	Absent Absent	Present Present	Constipated Diarrhea				
30 K.F.	40	F	Present	Present	Present	Absent	Irregular	41	.02		
31 T.M.	59	M	Absent	Absent	Absent	Present	Constipated				
32 A.F. 33 E.C.	56	M	Present	Present	Present	Absent	Constipated	14	0		
34 F.K.	$\frac{31}{37}$	$_{ m M}^{ m F}$	Present Absent	Absent Absent	Absent Present	Present Absent	Constipated Diarrhea	11 12	0		
35 C.L.	45	M	Present	Present	Present	Absent	Irregular	65	.16		
36 K.P.	40	$\mathbf{M}$	Present	Absent	Absent	Present	Constipated	9	0		
37 P.C. 38 H.T.	36 51	$_{ m M}$	Present	Present	Present	Absent	Diarrhea	8	0		
39 F.D.	34	F	Present Present	Absent Present	Absent Absent	Absent Absent	Constipated Irregular	8	0		
40 P.K.	49	$\dot{\mathbf{M}}$	Present	Absent	Absent	Absent	Constipated	-			
41 G.B.	53	M	Present	Present	Present	Absent	Irregular	11	0		
42 A.M. 43 C.E.	47 59	M M	Present Absent	Absent	Absent	Present	Diarrhea	9	0		
44 E.P.	40	M	Present	Absent Present	Absent Present	Present Present	Constipated Diarrhea	13	0		
45 N.R.	38	F	Present	Absent	Absent	Present	Diarrhea	46	.06		
46 K.O.	51	M	Absent	Absent	Absent	Present	Constipated				
47 W.S. 48 P.L.	$\frac{59}{47}$	$_{ m M}^{ m M}$	Present Present	Present	Absent	Present	Diarrhea	44	.12		
49 L.T.	53	M	Present	Present Present	Present Absent	Absent Absent	Constipated Diarrhea	11	0		
50 R.F.	57	$\mathbf{M}$	Present	Present	Present	Absent	Constipated	9	0		
51 H.S.	36	M	Absent	Absent	Absent	Present	Diarrhea				
52 S.F. 53 T.B.	$\frac{42}{30}$	$_{ m F}^{ m M}$	Present	Absent	Absent	Present	Irregular		_		
54 P.E.	55	M	Present Absent	Absent Absent	Present Absent	Absent Present	Diarrhea	10 38	.04		
55 T.L.	42	M	Present	Present	Absent	Absent	Constipated Diarrhea		eUE		
56 K.A.	61	M	Present	Absent	Absent	Present	Diarrhea	24	.02		
57 N.S. 58 O.J.	60 57	${f M}$	Absent Present	Absent	Absent	Absent	Diarrhea	7.4	_		
00 0.0.	01	TAT	resent	Present	Present	Absent	Constipated	14	0		

in which the physical characteristics as well as the examination of blood left no doubt as to diagnosis. The symptoms manifested were loss of appetite, nausea, vomiting, indigestion (fullness, pressure, distention), diarrhea and constipation.

Loss of appetite was observed in 38 cases, nausea in 27, vomiting in 19, indigestion in 33, diarrhea in 20, constipation in 27, and irregularity of the bowels in 11. The liver was enlarged in 18 instances while in 40 it was not. Enteroptosis was present in 21 instances and atony of the stomach in 29. Gastric catarrh was present in nine cases. The gastric contents were examined in 43 of the 58 cases. In 30 of these there was absence of gastric digestion (achylia gastrica). In nine the gastric digestion was diminished and in four it was normal. In the 30 cases with absence of gastric secretion the total acidity ranged between eight and 14. In the nine with diminished gastric secretion, the total acidity ranged between 22 and 46, free hydrochloric acid between 0.02 per cent to 0.06 per cent. In the four with normal digestion the total acidity ranged between 32 and 65, free hydrochloric acid between 0.11 per cent to 0.16 per cent. The gastric secretion was examined in five patients presenting an absence of free hydrochloric acid during the period of improvement in the state of the blood as well as of the general health; in none did the secretion return during the stage of apparent recovery. From a study of the 58 cases of pernicious anemia, it is evident that a large proportion of these cases are attended with gastro-intestinal disturbances as well as with an absence of gastric secretion; there is present an achylia gastrica in about 70 per cent of cases and even in the stage of apparent recovery the gastric secretion does not return. In a smaller proportion of cases, 20 per cent, there is a marked diminution of the secretion, and in a few instances, about 10 per cent, it remains normal.

It is quite probable that the poison which produces the hemolysis is the same which is also responsible for the alteration in the gastric secretion.

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### A CASE OF TYPHOID FEVER DEVELOPING DURING ANTI-TYPHOID VACCINATION.

### BY DR. STANDISH McCLEARY, '90.

While many such cases will doubtless occur as this procedure becomes more generally used, at this time it is sufficiently rare to present some points of interest.

The case in question is one of three cases of typhoid occurring in a family spending the summer at Glencoe, Md. These were the only ones known to exist in the neighborhood. The outbreak was almost certainly due to a polluted well and, to me, was not unexpected. The water supply of this house consisted of a spring, located about 200 yards from the foot of the hill on which the house stood, and a surface well within a few yards of the kitchen and under the same roof. The water from the well was distributed throughout the house by a good system of plumbing. About 25 feet from this well was a cesspool into which flowed the sewage from the flush closets and bath tubs.

In May, 1912, the family moved to this house from Baltimore, and sent samples of water from the spring and well to the State Board of Health and myself. Both samples were pronounced bad, that from the well especially so.

. The spring was cleaned out and a concrete wall built around it. The cesspool was emptied and then filled up with lime and earth and a new

one dug about 100 yards away on the opposite side of the house at the foot of a steep hill. After these changes a sample from each source was sent to the same parties for re-examination and both were reported to be in good condition, but the admonition was given that the water from the well was not to be used for drinking or in the preparation of food. The servants were instructed to use the water from the spring, in which the trouble had been only trivial, for the above purposes. The spring was inconveniently located, and it is not at all unlikely that, with the well-water at hand in the faucets, it was frequently used in place of the less accessible spring water. Everything was serene until July 31, when I was sent for to see J. D. H., Jr., age 3 years, 9 months, who had lost his appetite and been listless for several days. Knowing the situation, I was prepared to find typhoid, and took with me materials for making a Widal. I found the child with a temperature of 102.5°, drowsy, tongue coated, but no rose spots and spleen not palpable. I told the family I suspected typhoid and secured a nurse and treated the case as such. The Widal was "suspicious," but on the following day was positive and rose spots were abundant.

I examined the spring water and found it beyond suspicion, but the well water again showed extreme pollution. This was not surprising as recent heavy rainfalls had doubtless caused a seepage from the abandoned cesspool into the well.

The dairyman, located at Parkton, who supplied milk to the household, could give a clean bill of health, both on his premises and among his patrons. Feeling sure that the water was at fault and that I was dealing with a condition which might be followed by the infection of the entire household, I ordered the well disconnected and the spring water boiled, and further urged immediate anti-typhoid vaccination for the entire family, except a child under two years. All acquiesced but the cook. Those vaccinated were the mother, father, aunt, uncle and trained nurse. One of these, the aunt, Miss S., age 43, developed typhoid. She received with the others her first injection, 250 million, on August 3. On August 4 the local reaction was slight, and at 4 p. m., 24 hours after injection, the temperature was 101.6°. On August 5 had reached 102°, and my suspicion was aroused, as this was longer than the reaction temperature usually lasts when the subjective symptoms are mild as were hers. When

questioned she admitted she had been feeling badly for several days prior to her vaccination, and had suffered from headache, languor and loss of appetite. She had not referred to her condition for fear of adding to the worry of her sister, the mother of the sick child. I immediately made a blood culture, realizing that a Widal would likely be misleading on account of the vaccination. On the second day later the typhoid bacillus was obtained from the culture and a few rose spots appeared on the back. Her condition, aside from the headache and temperature of 102° was excellent, and she rode in a chair car to the hospital in Baltimore. Here the course was absolutely typical but in miniature. At no time was she toxic, the headache disappeared in two days, the mind perfectly clear, and under forced internal hydrotherapy the temperature did not go over 102°, and in two weeks from admission had regained the normal. Three weeks after admission she was discharged and rode 20 miles to her home in a motor car. The entire course of her illness can only be expressed as ideal. The vaccination was not completed in her case, but the others were given 500 and 1000 million at 10-day intervals. None of them have contracted the disease at this date, October 15. The cook who refused to be vaccinated showed symptoms of typhoid seven days after the vaccination was first given the other members of the household and developed a very severe case at her home to which she was removed.

The first case, that of the child, was a well developed one, and the temperature, after having lasted four weeks and reaching 104.9°, ended by crisis. These two cases would indicate that the organism in this outbreak was not wanting in virulence.

The few similar cases of typhoid developing during vaccination have run a like course and would seem to dispose of the question of danger from its use during epidemics, especially by nurses who are greatly exposed, and among whom typhoid is most frequent.

It seems most unlikely that anti-typhoid vaccination is followed by a negative phase for if such were true, its administration during the incubation period would be followed frequently by grave infections. All experience leads to the belief that it hastens the onset of symptoms and that the disease is of shorter duration and less severe in character. Its use in infected households and in those engaged in attendance seems not only safe but desirable.

## THE ADVANTAGES OF OPERATIONS FOR THE CURE OF HERNIA.\*

### BY ALEXIUS McGLANNAN, M. D., BALTIMORE.

It is a generally accepted fact that the ideal method of dealing with a hernia is by operation. However, on account of the rather large number of otherwise healthy people who have an inguinal hernia and spend years in a state of at least partial disability, it seems wise to call attention to the character of the operation for the cure of hernia and to some of its great advantages over other forms of treatment.

The non-operative treatment is limited to the proper fitting of a truss. The various injection methods of treatment are indefensible. These irritant liquids set up a plastic inflammation which is always liable to injure the cord, and may include the bowel in its resolution. When the patient escapes these dangers he is still far from a certain cure, because the plug of scar tissue is very likely to give way and stretch under pressure. This fact was recognized long ago and was the cause of failure in the McEwen operation.

The art of truss fitting is not a common accomplishment among medical men. The fitting is usually done by the instrument maker without any supervision. A properly applied truss is rarely seen. Most men wear the pad over the external ring, thus allowing the bowel to slip into the inguinal canal, where it becomes subject to strangulation and other traumatisms, at the same time making the size of the hernia greater. In other cases the truss presses on the pubic bone, compresses the cord, and in this way leads to varicocele and atrophy of the testicles. A large hernia will require the wearing of a truss both night and day. "The one that is exactly suited for the day is entirely unsuited for the night, and the reverse holds equally true." (De Garmo.)

Even the best-fitting truss is uncomfortable to wear, and therefore we find patients leaving off this apparatus whenever any excuse to do so is offered. Strangulation is the common result, and then an emergency operation is the only alternative. All the risks are now intensified and many of the certain advantages of the elective operation are lost.

Against these disadvantages and dangers we must measure those of the elective operation. First of all, the probability of permanent cure after

<sup>\*</sup> Reprinted from Maryland Medical Journal, August, 1910.

operation is important. This is practically certain. The recurrence of a hernia after proper operation is extremely rare. De Garmo had 19 recurrences in a series of 1411 operations, including 45 strangulated hernias. The mortality following elective operation is so slight that it is negligible. With strangulation an appreciable mortality comes in at once; the toxemia of obstruction and the occasional enterostomy and other additional operations increase the danger. It is our belief, therefore, that any patient whose general condition is such that any operation is justifiable should be operated upon for the cure of hernia before strangulation makes this imperative. The danger incident to the operation is much less than the risks and inconveniences of the non-operative treatment. An untreated hernia is of course a most serious menace to its unfortunate possessor.

We prefer to do hernia operations as elective procedures after careful study and preparation of the patient. This preliminary study includes a general investigation of the condition of the lungs, organs of circulation and the kidneys. Deficiency in the function of any of these organs does not contraindicate operation, but leads us to take certain precautions in the preparation of the patient, the choice of the anesthetic and the aftercare.

The Preparation of the Patient.—This will require varying lengths of time. With an otherwise healthy individual the bowels are thoroughly emptied by means of a purgative and enemas given 24 and 12 hours before operation. The diet is restricted to liquids without milk during this time, and the patient is encouraged to drink a large amount of water. It is better to have him spend this day in bed and practice the use of the bed pan and urinal in the recumbent position. Fat people are given several days in bed on restricted diet. Buttermilk diet with little carbohydrate is best.

The urine must be studied for evidence of acidosis. Should this occur, alkalies are given until it disappears. Kidney insufficiency is a serious matter, which must be studied with care. When the routine examination of the urine shows any evidence of severe disease of the kidneys, one of the colorometric functional tests should be employed. The phenolsul-phonphthalein method of Geraghty and Roundtree seems the best of those described.

In the presence of evidence of serious functional disturbance of the kidneys operation must be postponed. We have found the use of cream of tartar lemonade in large quantities a valuable means for stimulating the kidneys. In the case of men who are accustomed to rich food and alcohol this preliminary treatment of the kidneys is always necessary without regard to the condition of the urine.

Circulatory disturbances may require long and careful preliminary treatment. Alkaline waters, sparse diet with complete emptying of the bowels, and as far as possible the disinfection of the intestinal tract, are required when sclerosis is present.

Myocardial and endocardial lesions, if severe, so limit the activities of the patient that the truss treatment is sufficient for the relief of the hernia. When the patient's heart allows him to be active its condition is not a bar to operation.

Chronic lung disease may become an urgent cause for operation for hernia. Severe coughing may cause strangulation. Anodynes should be given before and after the operation in order to limit the amount of coughing, and a local anesthetic or nitrous oxide should be used.

Anesthetic.—Hernia operations may be performed in the most satisfactory manner with local anesthesia under certain conditions. A large hernia that has stretched the tissues of the abdominal wall makes the suture easy, while a small hernia may give some difficulty on account of rigidity of the muscles. Children and nervous or frightened adults, however, cannot be managed, and so a successful operation cannot be done. Strangulated hernia is best done under local anesthesia.

Morphine, one-sixth grain, and atropine, one-one-hundred-and-fiftieth grain, are given hypodermically as soon as the patient reaches the operating-room, before his skin is prepared.

Nitrous Oxide-oxygen.—This is rapidly becoming the favorite anesthetic for most operations. The principal obstacle to its general use is the expense. An hour's anesthesia requires about \$5 worth of gas. Occasionally the muscles do not relax, but in such cases a little ether may be added at the time of making the suture. Patients come out of this anesthesia almost simultaneously with the end of its administration, and the nausea and other disagreeable effects of ether are absent. This gas anesthesia is the method required whenever there is disturbance of kidney, lung or circulatory function.

Ether by the open drop method is still the simplest and most generally accepted method of anesthesia in uncomplicated cases. If the patient has been well prepared there is little or no post-anesthetic distress.

The Operation.—The present-day operation is the result of years of experience and experiment. The bad results and failures of many methods have been eliminated, until now we operate on an inguinal hernia with a confident expectation of permanent cure without complications. After the operation the abdominal wall is not only made as good as normal, but even stronger. The principle is a good muscle suture after caring for the sac.

The canal is opened through a skin incision beginning about 3 cm. above the line of Poupart's ligament, about 4 cm. from the anterior superior spine. This incision is carried to a point over the pubic spine and down to the aponeurosis of the external oblique. This aponeurosis is exposed until Poupart's and the external ring are well uncovered. The canal is now opened by cutting the aponeurosis in the line of its fibers. The lower flap is dissected back to show the shelving portion of Poupart's ligament, and the upper flap until the sheath of the rectus comes into view. As soon as the canal is opened the cord is exposed and the ileo-inguinal nerve is seen on its surface. The isolation of the nerve is an essential point in a cocaine operation. The preliminary steps can be done under infiltration, but further procedure requires that this nerve be blocked by injecting cocaine into its sheath at the upper part of the wound.

The sac is now picked up and separated from the cord by careful dissection with a sharp knife. The vessels are not disturbed any more than is necessary, and the vas with its artery and veins should not be handled. When the veins are large or varicose they are excised after careful separation and ligation. Rough handling of the cord is responsible for the elephantiasis of the scrotum and the atrophy of the testicle following hernia operations. The sac may be opened either before or after this separation is complete. After any adhesions within the sac have been divided the neck is transfixed and closed and the lower portion removed. The stump of the sac is drawn up under the internal oblique by means of a suture passed through this muscle from its under surface about 2 cm. above the internal ring. This maneuver comes from Kocher, and is in-

tended to so alter the direction of the funnel-like intra-abdominal surface of the ring that the pressure is exerted away from the apex.

After disposing of the cord the reconstruction of the abdominal wall is begun. This first suture brings the conjoined tendon down to the shelving portion of Poupart's ligament, and the succeeding ones bring the internal oblique into contact with this same tissue. The cremaster is included in this layer of sutures. Next the external oblique is closed with overlapping by an imbricated suture. The skin is approximated by any desired method.

When the external ring is very large, when the conjoined tendon is thin, and especially in direct hernia, the rectus sheath and rectus muscle transplanted operation devised by Dr. Halsted and Dr. Bloodgood becomes necessary.

We have made it a rule to take out the appendix when doing rightsided hernias, whenever there is no direct contraindication.

It is not uncommon after operation for cure of a unilateral hernia to have the patient return with a hernia on the other side. Therefore, with young people having a unilateral hernia we do a hernial suture of the canal on the other side, if the condition justifies this additional operation.

The patients are kept in bed about 10 days. We give morphia during the first 24 hours after operation if there is restlessness. Continuous salt solution per rectum for six or eight hours and then 500 cc. three times a day aids in the elimination of the anesthetic and adds to the patient's comfort.

Patients who are suffering from some complicating disability are given appropriate treatment. The more important groups have been discussed in connection with preliminary treatment. We find spartein sulphate in quarter- and half-grain doses valuable as a stimulant to deficient kidney function. Eserin, one-sixty-fourth grain, is useful in treating post-operative distension of the bowels. The drug is given hypodermically, and its administration should be followed by the insertion of the rectal tube 20 minutes later. The pain that accompanies the muscular contractions necessary to overcome the action of the sphincter is enough to prevent this activity, and the tube avoids the dilemma.

The use of the catheter is often required, but in proportion to the amount of preliminary training patients are given in the recumbent use of the urinal and bed pan they will need less and less catherization.

These patients get up from the 10th to the 14th day, and most of them go home on the 18th. All dressings are removed before this time, and after a bath a muslin spica is put on in the erect posture. This is changed daily and is worn for about two weeks. After this time no apparatus of any kind is worn, and the patient goes about sound and secure.

### CHANCRE AFTER SALVARSAN.

BY MELVIN S. ROSENTHAL, '91.

In these days of "Salvarsanomania," when layman and professional alike are blindly pinning absolute faith in the newly discovered drug, it is well to pause in our enthusiasm and remember its shortcomings in conjunction with its manifold virtues. Unfortunately Ehrlich's hope of having discovered a "therapia sterilisans magna" has been disproven and so accepted. It is especially unfortunate, since with its introduction came the testimony of many observers that a single dose had cured the disease. Thousands of syphilitics are to-day living in a state of false security, convinced of their recovery from the dread syphilis, because of a single injection. The misconception concerning the use of 606 can be readily understood if we but recall how its praises have been lauded in the medical press, how its virtues have been preached from the pulpit and platform, how it has been illustrated in the magazines, and how column upon column has been devoted to it in the daily press. Every person who had ever had syphilis, every person who ever thought he had had syphilis, and every person who ever expected to have syphilis immediately enrolled under the standard of 606. This includes a vast army of syphilitics, an enormous number of syphilophobiacs, and a goodly number of syphilophobiac-quacks, professional and otherwise. With a more careful revision of statistics and a closer observation of its effects, salvarsan is beginning to assume a sane position as a therapeutic measure, and it is to be hoped that before long its real possibilities will be accurately ascertained and its use limited to a definite field.

The following case is unique and presents a series of events as yet unrecorded:

February, 1905, J. B. came to me suffering with an indurated sore on the penis which had persisted for nearly three weeks. There was a double inguinal adenitis, extensive macular eruption, patches in the mouth and on

the tonsils. A diagnosis of syphilis was made and the patient given the inuncti on treatment. For three years he religiously followed the treatment, which consisted of inunctions at first, followed later by mercurial injections, and at varying intervals mercury by the mouth.

March, 1910, the patient returned with the history that for two years he had done nothing in the way of treatment for his syphilis. He had been absolutely free from any symptoms and enjoyed good health. He weighed 190 pounds which was 20 pounds more than he weighed before contracting the disease. He consulted me as to the advisability of having a Wassermann test, having read of the infallibility of the reaction. His mind was unduly occupied with matters syphilitic and he was well informed on recent advancements in the study of the disease. The Wassermann report was negative. The combination of events prompted me to assure the patient of freedom from future complications.

December, 1910, the patient insists on a confirmatory Wassermann since reading that "a positive Wassermann is proof positive of the existence of the disease, but a negative result may be accidental or transient." The second report gave a similar negative result.

Examination. November, 1911, the patient presenting the following symptoms, applied for relief. For several months he had periodic attacks of intense pain radiating down the legs. He at first attributed them to exertion but since they came on independently of any exercise he abandoned that theory. He had also had irregular abdominal pains at times, followed by nausea and vomiting, but unassociated with the presence of food in the stomach. The knee-jerk was lost on the right side, and diminished on the left. A provisional diagnosis of locomotor ataxia was made.

January 5, 1912. Since his last visit the patient has consulted Dr. Peterson, of New York, who confirmed the diagnosis of locomotor ataxia and advised the use of salvarsan.

Treatment. On Jan. 8, an intravenous injection of salvarsan 0.6 gm. was followed by slight discomfort, dizziness and headache for several hours. January 12, the patient showed a small erosion on the glans penis, which looked not unlike an abraided surface after a vesicle had ruptured. Having on numerous occasions seen herpes follow the administration of salvarsan I concluded that the sore was herpetic, and prescribed accordingly. January 18 the sore was distinctly indurated and there was some inguinal adenitis, although spirochætes were not found. I am frank to admit that I was not disappointed at the failure to find the organism, being satisfied the sore was an infected herpetic eruption. Local treatment (B. & C.) of the sore was stopped and on January 22 the edges of the sore were markedly indurated the inguinal glands were large, and a decided macular eruption appeared on the body. An examination of the serum from the sore showed undoubted spirochætes and a Wassermann made the following day was actively positive. There has been no change in the tabetic symptoms. A week later the patient left the city and I have been unable to get into communication with him since that time.

The unusual features of this case are first, the development of a disease presumedly of syphilitic origin, in an individual giving repeated negative Wassermann reactions; second, that a man suffering from the direct effects of syphilis should contract a chancre; and third, that a chancre should develop four days after an intravenous injection of salvarsan. I feel confident that the possibility of faulty technic or other errors in making of the serum reaction may be eliminated, since they were made by a laboratory worker of undoubted skill and ability.

#### EXTRA GENITAL CHANCRES.\*

BY MELVIN ROSENTHAL, M. D., BALTIMORE, MD.

The rapid strides made in the study of syphilis in the past few years is a striking refutation of the stigma that the advance in medicine is slow. While we are continually reminded that surgery is progressing with giant strides, yet in spite of the advances in scientific methods of diagnosis, the treatment of disease remains frequently inaccurate and unsatisfactory. It is but a short time ago since our entire knowledge of the diagnosis of syphilis depended upon a clinical picture only too often erroneous. Patients presenting themselves with early evidences of infection were confronted with the dubious statement "to await developments." This meant that if certain so-called classical symptoms did not follow, if there was no eruption, no adenitis, no mucous patches, no alopecia within a specified time then the patient and the doctor could feel reasonably sure the lesion was not luetic. Of the countless cases of simple erythemas, stomatitis, alopecias which were subjected to the rigorous and nerve-racking mental torment of three to five years of antisyphilitic treatment and a life of doubt and fear, let us draw the curtain. On the other hand in those cases of delayed secondaries when, after the usual dormant period where the patient possessed that subtle something, we as yet do not understand but are content to call resistance, and the fears of the patient had been quieted as to the possibility of syphilitic infection, he returns in two or three months with the tell-tale eruption, rapidly followed by vigorous and often malignant manifestations of our error, what subterfuges. excuses and apologies were adroitly employed to restore the lost confidence.

The universal teaching of but a few short years ago, was that a patient with a genital sore, soft or hard, with or without adenitis, "await sec-

<sup>\*</sup> Reprinted from American Journal of Dermatology, March 11, 1912.

ondaries, they usually appear within two or three weeks after the initial sore." Physicians who see many cases of genital lesions can recall frequent instances of infections which at first sight presented all the physical characteristics of Hunterian chancres, single, round, superficial cupshaped sore, with scanty secretion, indurated with a bi-lateral adenitis and not painful, only suddenly to become large, irregular, painful, with abundant secretion and rapidly forming bubo, clearly indicating a purely local infection. To prognosticate the future of any sore at first sight was often an impossible task. To begin treatment at once for syphilis was to condemn the patient to a life of doubt and to await secondaries was to subject the patient to the ravages of the organisms until they had developed in sufficient numbers to overcome the natural resistance, destroying all barriers and asserting themselves in no uncertain terms. It is not to be wondered that many virulent cases of syphilis resulted and that tertiary lesions are found in a large proportion of infections. With the discovery of the spirocheta by Schaudin and Hoffman, rapidly followed by the serum diagnosis of Wassermann and terminating with the Ehrlich Salvarsan, we have a clinical, diagnostic and therapeutic triad with which we hope rapidly to overcome many of the ravages of the dreaded syphilis. I advisedly say "hope to overcome" since in spite of the belief of many of our colleagues, the millennium has not yet arrived. The wild enthusiasm with which Salvarsan was received is simmering down to a realization of the fact that an important adjunct to the treatment of syphilis has been discovered. Failures, recurrences and untoward results are being reported and we will soon recognize that the temporary disappearance of the spirocheta, a suspended or delayed Wassermann is not sufficient evidence on which to pronounce a patient cured of the disease.

It is a well-known and established fact that sores on or about the genitals, even in the most virtuous, immediately arouse suspicion and medical advice is at once sought. In the light of our recent knowledge concerning syphilis we can in a large proportion of cases immediately determine the presence or absence of the disease. It is fervently hoped and expected in the very near future, diagnosis, followed immediately by specific treatment, will in a short time eradicate all evidences of the scourge. There are, however, a number of cases, unfortunately a large number, in which the initial sore is not situated on the genitals but

makes its appearance on some unusual site. Instances are frequent in which small innocent-looking sores appearing on the finger, lip, tongue or tonsil, arouse no suspicion until like a bolt from a clear sky, the patient is suddenly confronted with alarming evidences of luetic infection. Sores in these situations are too frequent to arouse suspicion, and there is no doubt that the early secondaries, the slight erythematous or macular blush for which we so diligently search when associated with genital sores, entirely escape observation when the original sore is extra-genital. These cases frequently go on for months untreated. The organisms increase unmolested until their virulence suddenly is asserted in no uncertain terms. To my mind the persistency and obstinacy of secondaries and tertiaries associated with extra-genital infections is due to the long interval which usually intervenes between the time of infection and until diagnosis is established and treatment instituted. This interval in the case of suspected genital infections where we are on the alert for the early secondaries, is a comparatively short one and these cases come under treatment early, with consequent mild late lesions in the large number of cases. Extra genital lesions remaining unsuspected for a long time, the interval between infection and the institution of treatment in the vast majority of cases is decidedly longer than in the case of a genital infection. In a general way it may be said that the longer the interval between infection and treatment, the more syphilized or saturated the patient and consequently the graver the symptoms.

The following cases of unsuspected syphilis will illustrate the intractability of the disease in cases of unusually long periods intervening between the time of infection and the institution of proper treatment.

X, a physician, presented himself with a profuse maculo-squamous eruption of the body, face and head, mucous patches in the mouth and a general glandular enlargement. Twelve weeks before while making a dorsal incision in an obscure intra-preputial sore, he pricked the thumb of the right hand. Four weeks later there appeared a small indurated sore on the site of the injury with lymphangitis. Application of wet bichloride dressings rapidly healed the wound and reduced the swelling. Ten days later the eruption appeared spreading rapidly. Three weeks' course of the inunction treatment completely cleared the eruption and internal treatment was given. After three weeks the eruption re-appeared and inunctions made but slight impression. Patient went to Hot Springs,

Arkansas, remaining under treatment for three months when all evidences of the disease had disappeared. In spite of vigorous and conscientious treatment, the patient has had two or three outbreaks for seven years. When last seen, about a year ago, Wassermann still positive. In this case ten weeks elapsed from the appearance of the disease until proper treatment was instituted.

Case 2. A large indurated ulcer of the upper lip persisting for nine weeks. Marked tubercular eruption of the arms and legs with a fading macular of the body. Only local treatment had been used for the ulcer and the eruption. Inunctions given by a thoroughly experienced masseur had little or no effect in arresting the progress of the disease. The tubercles rapidly broke down leaving deep ulcerations healing slowly after months of persistent treatment. Intermittent ulceration for three years. At the present time nodules in the skin, indurated glands marked, positive Wassermann. This patient was given no specific treatment for nine weeks after the chancre made its appearance.

Case 3. White female, has been suffering with psoriasis for ten years. In November, 1906, during an attack of acute psoriasis noticed a small ulcer on lower lip. The ulcer was indurated, persistent and did not yield to ordinary treatment. Had been using Fowler's solution in fivedrop doses for several months. When first seen by me, January 27, 1907, patient had a well-marked psoriasis. In addition there was well-established evidence of syphilis, mucous patches in the mouth, on the tongue and tonsils, alopecia, condylomata of the rectum, and a general adenitis. In spite of rigid antisyphilitic treatment the eruption persisted involving the face in a most unsightly pustular syphilide. In March, 1907, symptoms of melancholia with suicidal tendencies necessitated her removal to an asylum. Neither intra-muscular injections nor inunctions had any decided influence on the disease. Patient committed suicide in June, 1907. At the time of her death there was extensive pustular eruption of the integument with mucous patches and adenitis. Patient had remained without anti-syphilitic treatment for about ten weeks after the appearance of the initial lesion.

Case 4. White female, presented herself March 27, 1908, with profuse circinate syphilide, marked general glandular involvement, alopecia, and large mucous patches of the mouth and tonsils. In the latter part of December, 1908, had a persistent ulceration of the right nipple with

glandular enlargement. About the middle of January, had a general scaly eruption of the body. The present crop of cincinate syphilides has been evident for about three weeks. Inunction treatment cleared the skin and mucous membranes in a short time but an iritis persisted after all evidence of the skin manifestations had disappeared. In June, 1908, while under the intra-muscular treatment, large pustular syphilides developed which yielded after two months. Early part of November, suffered several weeks with violent headaches. On November 19, woke up with a left sided hemiplegia. Gradually recovered use of limbs after use of iodides. On January 2, 1911, patient showed a large broken down gumma of the scalp. On January 5, 1911, intravenous injection of salvarsan followed in two weeks by good results. Wassermann, made January 20, still actively positive. Patient remained without specific treatment for nearly three months after the initial lesion appeared.

With the advent of our newer methods of rapidly staining the spirocheta and simplifying the Wassermann diagnosis we hope to be able to give an immediate opinion on all sores, and institute the proper treatment at once. If a simple infected sore, herpetic or otherwise, a mild antiseptic and resolution rapidly ensues. If chancroidal, the usual strong caustics, deep sloughs, buboes, tortures mental and physical, a cicatrix and all is forgotten. If syphilitic, the presence of the organism determined, a syringeful of salvarsan or some modification of the same, a slight pain and induration over the seat of injection and the worst is over. The millennium will have been reached. Paresis will be eradicated. Tabes rare, gummata unknown, hemiplegias and paraplegias occur only after eighty, dermatologists will have lost a most valuable asset and syphilographers, will be but a name, a relic of a barbarous past.

#### MEDICAL NOTES OF A PERSIAN PHYSICIAN.

BY JONATHAN PETROS,\* OF HASSANAHAD, TEHRAN, PERSIA.

As to sanitary conditions in Persia, there are none; the department of sanitation here is in the hands of Nature. The people, as it were, are trying their best to violate every one of the sanitary rules, and yet, comparatively

<sup>\*</sup>Dr. Petros, after his graduation, served as a resident physician at the Mercy Hospital and subsequently at the Baltimore Eye, Ear and Throat Charity Hospital. At the request of Dr. Harry Friedenwald, he sent him these notes.

speaking, there is less sickness than one ought expect. This is very likely due to the high altitude, the dry, rarified air, the disinfecting power of the direct rays of the sun, and also because this is a decidedly mountainous country.

Although the water supply here is very defective, yet there is less typhoid fever than I saw in Baltimore, and what cases one does see here are mostly the mild paratyphoid fever than the severe typhoid fever.

Malaria in all its types is seen rampant on every hand, almost all year round, raging most intensely between June and October. There is a greater mortality amongst babes and little children. Just as in the States, typhoid fever is often marked by its manifold complications, e. g., meningitis, pseudohemiplegia, monoplegia, neuritis, aphasia and eye involvements, etc. Malaria is likewise doing the same thing here, for example: A typical case of hemiplegia aphasia accompanied with unconsciousness occurred in a young person at the acme of malaria season. It resisted every treatment, but he soon recovered after receiving a few 20-grain doses of quinia bihydrochlorate hypodermatically.

A case of severe meningitis of two months' duration resisted every treatment, but soon got well after receiving a few massive doses of quinine bihydrochlorate given hypodermatically.

A young man suffering from an excruciating headache for one month, was only relieved with hypodermics of morphine, three times a day. Besides complaining of his headaches, he had a marked divergent strabismus and its associated diplopia. His gait was incoordinated and he would often fall when attempting to walk. The eyegrounds showed large choroidal hemorrhages. Ten hypodermics of grs. XX doses of quinia bihydrochlorate relieved the headache; the strabismus and the diplopia disappeared, and he had an uninterrupted convalescence.

It is noteworthy that here in some obstinate cases of malaria, quinine given internally does practically little good, but when in the form of quinine bihydrochlorate, given hypodermically, its good effect is almost immediate.

The reason that malaria is so prevalent in this country is but partly explained because of the fact that it has some marshy land. An important contributing cause in the cities is the defective water supply and the demand of the Mohammedan religion; for a Mohammedan must pray five

times a day, and every time he prays he must have a ritual wash. Therefore every up-to-date house from a Moslem standpoint, must have a pool of water in the court-yard. These pools are replenished with fresh water once in a great while, and usually they are full of stagnant water. Thus each house has a bed for the anopheles mosquito to breed its young ones and disseminate malaria.

Persia is one of the best fields for ophthalmology. There is more eye trouble here than any other two or three troubles put together. There are a good many cataract cases here. I have already operated twice for cataract extraction—both patients now see well. I have done a few iridectomies for relief of glaucoma. Of course trachoma is plentiful in all eastern countries, and Persia is no exception to this rule. But there is another condition found here, simulating trachoma, which I have learned to look upon as a primary tuberculous manifestation in the eye. Like trachoma, the lids are granular; in some there is a typical pannus (at times covering the whole cornea); in others there is keratitis or sclerokeratitis. While trachoma is usually bilateral, this condition is unilateral, and at times alternating. Copper sulph. does them more harm than good. Associated with the eye condition, these patients, who are mostly young girls between 14 and 20 years of age, have a little temperature, increased pulse rate, and low tension as in tuberculosis. They also give a history of loss of weight, anorexia and a great dislike for nitrogenous food; some of them have night sweats also. The Calmette tuberculin test proves positive. None of them suffer from any cough, expectoration or dyspnea, but upon physical examination I have not been able to find any lesion in the chest.

I have been inclined to think that the high altitude and the rarified air of this country removes a good deal of the strain on the cardio-respiratory systems, and if there is any latent tuberculous mischief in the body it does not reveal itself in the lungs, but in a weaker organ, which, in this country, happens to be the eye, which is strained most because of the brilliant sunshine, intense heat and increased dust. I would like to know your opinion about these eye cases, as I have thought to drop tuberculin sol. in these eyes, if you think it advisable.

WILLIAM S. GARDNER, M. D., EDITOR, 6 W. Preston Street.

JOHN RUHRÄH, M. D., Associate Editor 839 N. Eutaw Street.

CHAS. EMIL BRACK, M. D., Business Manager, 500 E. Twentieth St.

#### THE JOURNAL

#### OF THE ALUMNI ASSOCIATION

OF THE

### COLLEGE OF PHYSICIANS AND SURGEONS, BALTIMORE.

#### CHANGE AND IMPROVEMENTS.

The present session of the college has been marked by great advances. The new life infused by the devotion and the untiring activity of our new Dean, Professor Lockwood, has shown itself in a marked change in the appearance of the building. During the summer the entire college was renovated and put into splendid condition. The cordial co-operation of the students has enabled the faculty to preserve order and cleanliness in class room, laboratory and hallway.

The physiological laboratory has been placed on the main floor, and is roomy, well equipped and well lighted, and the laboratory work is most satisfactory.

The use of the rooms formerly occupied for the resident physicians by the medical department of the dispensary has been of the greatest benefit. There has been a marked growth of the department in the character of the work done.

The library has been improved by the addition of several hundred volumes, and the addition of forty standard medical journals.

The increased needs of the Dean's department have necessitated the taking in of the former janitor's room, and we now have convenient offices for the elaborate system of college records, which modern requirements demand.

The greatest step forward during this session was the selection of six full-time instructors. The advantage of this step is evident, and has proved of great benefit.

Under these circumstances we feel that we fully deserve the rating which has been given us, not only by the Board of Regents of the State of New York, who have registered our school among those to whose graduates they give full credit, but also by the Council on Medical Education of the A. M. A., which has placed our school among those of Class A. This result of our efforts is the source of gratification to every member of the school, and is the greatest incentive in bringing out the best work that is in us. We feel that we cannot serve our Alumni better than by advancing their Alma Mater.

HARRY FRIEDENWALD.

#### NOVEMBER MEETING OF THE TRI-STATE CHAPTER.

The first fall meeting of the Tri-state Chapter of the Alumni of the College of Physicians and Surgeons was held at the Manhattan Hotel, New York, on November 14, 1912. The program was as follows: "Interpretation of Early Symptoms of Diseases of the Stomach," by Joseph W. Malone, M. D., of Brooklyn. "Phlyctenular (Eczematous) Conjunctivitis and Keratitis with Special Reference to Etiology and the Value of Tuberculin as a Diagnostic Agent, with the Report of Forty Cases," by Harry Vaughan, M. D., of Morristown, N. J.

Dr. Malone's paper was full of wisdom concerning diagnostic pitfalls and misleading symptoms, and was plentifully interspersed with illustrative cases from his own practice. Particular stress was laid on the large class of cases in which pain is elicited at points distant from the pathological lesion. Dr. Vaughan laid before the society the results of a piece of research work he has been doing at the Post-Graduate Hospital in conjunction with Dr. A. Edward Davis. They have devoted considerable time and attention to an investigation of the causation of phlyctenular conjunctivitis and keratitis. Various theories have been investigated and compared with conditions found to exist in their work. Dr. Vaughan's paper reviewed the various theories of etiology, and then dealt particularly with their experience in the use of tuberculin in the subjects of phylctenular conjunctivitis and keratitis. He closed by reporting 40 cases they had been able to follow closely during the course of the tuberculin inoculations. The results of the tuberculin treatment were: 26 cases, or 65 per

cent, were cured; 8 cases, or 20 per cent, were improved; 1 case, or 2.5 per cent, was unimproved; while the results in 5 cases, or 12.5 per cent, were unknown, the patients not returning to the clinic, nor could the visiting nurse locate them.

A large number of graduates of P. & S. were present at the meeting and took part in the discussion of these two interesting papers. After the scientific session a banquet was served in the dining room of the Manhattan Hotel. During the afternoon the members visited Bellevue Hospital as the guests of Dr. George F. O'Hanlon, Superintendent. The various departments of the hospital were inspected, and demonstrations were conducted in the operating rooms, laboratories, and X-ray rooms.

#### Personal Potes.

DR. CHARLES B. SMITH, '91, is mayor of Washington, N. J.

Dr. Robert Wriston, '05, is president of the Raleigh County Medical Society.

Dr. Michael Albert Abrams was married to Miss Marie Silberstein, of Baltimore, on November 28, 1912.

Dr. Edward C. Bennett, '12, was married to Miss Carrie Emerson, of Baltimore, on Tuesday, October 15, 1912.

DR. DAVID HOLT, DR. R. S. GRIFFITH, DR. W. I. McIntosh, all located in Louisville, returned to the college for a flying visit.

Dr. Paul M. Carrington, of the Marine Hospital Service, has been appointed Professor of Hygiene in the St. Louis University School of Medicine.

DR. OLIVER S. LLOYD was married to Miss Golda Lillian Pearce on Thursday, November 28, 1912. They are making their home at 1394 W. North Avenue.

DR. AND MRS. GEO. FLOYD GRISINGER are receiving congratulations on the birth of a son, George Floyd Grisinger, Jr., who was born on the 5th of January, 1913, at Vanetta, W. Va. DR. THOMAS RODNEY CHAMBERS was married to Miss Martha Virginia Sisson, of Baltimore, on Wednesday, November 6, 1912. They are making their home at the Mt. Royal Apartments.

Dr. William E. Fitch, 355 W. 145th St., New York City, is anxious to hear from every physician who has experience in the treatment of diabetes mellitus. Dr. Fitch is making a special study of this disease.

Dr. N. G. Karakala, '06, of Mardin, Mesopotamia, Asiatic Turkey, who is lieutenant in the Egyptian army service in the Medical Corps at Cairo, is engaged to Miss Stella Eiley Toal, daughter of Mr. John Toal, 530 E. 20th St.

LIEUTENANT H. M. COHEN, '96, has just returned from several years service in the Philippines. He entered the army service some years ago, and after some years' service in the early occupation of the Philippines, returned to Baltimore, where he practised several years. He again entered the army service and is quite enthusiastic about the work which has been done in our eastern possessions.

Dr. WM. J. WALKER, '08, of Mabscot, W. Va., is a member of the State Executive Committee and chairman of the Raleigh Progressive Party. Dr. Walker has taken an enthusiastic part in the formation of the Progressive Party in this state and county, and has sent us a copy of a statement which he has recently made in the West Virginia press, which is most optimistic for the future success of that party in West Virginia.

Dr. W. A. Gordon, '93, has recently purchased a half interest in the Hotel Elkton at Elkton, Rockingham County, Va. This hotel is situated near the famous Elk Lithia Springs in the Shenandoah Valley, and is a much frequented summer resort with all the advantages of sanitary improvements and surroundings. Any of our alumni sending patients will do well to call the attention of the fact to Dr. Gordon, who will give them his personal attention.

Dr. Charles G. Miles, '08, of Brockton, Mass., the city physician of that town, recently made his report to the overseers of the poor in which he urges that legislative action be taken to remove the office of city physician from the sphere of political influence. A part of Dr. Miles' report is as follows:

"In the past year 2462 calls have been made for the various departments and 246 calls for the so-called worthy poor, making a total of 2706 cases. In the three years I have held this office 7515 calls have been made for the various departments and 613 calls for the worthy poor, calls that I did not have to make, but did so as an act of charity. This makes a grand total for the three years of 8128.

"I must again call your attention to the need of an auto-ambulance for the city, the only one now being that of Cushing Bros. Perhaps some arrangement may be made with this firm for the use of the ambulance to handle city cases, if it is thought that the city cannot afford to purchase one. Something should be done to provide for accidents and emergency cases other than to use the police patrol.

"I must also call your attention to my recommendation of two years ago to provide for a suitable place for the temporary and also the permanent insane while they are awaiting commitment to some institution. Surely the police station is no fit place to keep a man or woman that is mentally sick and I feel that I am not asking too much when I remind you to look carefully into this recommendation before you pass it by without taking action.

"I would also recommend that the emergency room in the police station be fitted up in first-class shape to handle all kinds of accidents and emergency cases, subject to the approval of the city physician.

"I feel at this time that legislative action should be enacted in such a manner that the overseers of the poor should be given the power to appoint the city physician for three years and thus take this important office out of politics. There is no question in my mind that it costs the taxpayers hundreds of dollars in constantly breaking in a new man for this line of work for the city.

"In conclusion, I want to thank the Visiting Nurses' Association for the valuable assistance they have given me in the three years I have held this office. I also wish to thank the various officials connected with the different departments and especially W. S. Bamford and Miss Jessica Hines, of the poor department, also Warden and Mrs. Brown of the city home."

#### Dbituary.

Dr. John S. Garman, '78, died at his home in Berlin, Pa., October 2, aged 52.

Dr. Griffin T. Dailey, '84, died suddenly at his home near Romney, W. Va., November 22.

Dr. John W. Hughes, '11, of Pawtucket, R. I., died at the home of his father in Westerly, R. I., September 26, from nephritis, age 29.

Dr. Charles L. Kennedy, '97, of Troy, S. C., while driving over a crossing of the Charleston and West Carolina Railway, near Troy, December 26, was struck by a train and instantly killed, aged 38.

Dr. Leona M. Archey, '80, a member of the American Medical Association, assistant surgeon of the First North Carolina Infantry, U. S. V., during the Spanish-American War, died at his home in Concord, N. C., December 29, from heart disease, aged 59.

DR. CLARENCE W. ZURCHER, '11, who served as interne in the Mercy Hospital, and subsequently started to practise in Leetonia, Ohio, died suddenly, December 26, from scarlet fever after an illness of a few hours. He was a member of the Delta Alpha Ipsilon chapter of the Phi Delta Delta and the Chi Zeta Chi.

Dr. William A. Dorsey was instantly killed by a live wire at Sedro-Woolley, Washington. He was buried at Governors Run, Calvert County, Md. Dr. Dorsey served as a resident in our maternity hospital in 1908, and as resident in the Mercy Hospital in 1907. He was very conscientious in his work and made many friends. He had a most promising career and his loss is deeply felt by all who knew him.

Dr. Wm. L. Ziegler, '81, a member of the Medical Society of the State of Pennsylvania and for two terms a member of the city of Steelton and also a member of the local Board of Education, died at his home in Steelton, January 20, from pneumonia, aged 57.

Dr. Ziegler was engaged in the practice of medicine and also conducted a drug store. He was buried in Halifax. He is survived by his wife, three sons and one daughter. The American Surgical Association has appointed a committee consisting of Drs. William L. Estes, South Bethlehem, Pa.; Thomas W. Huntington, San Francisco, California; John B. Walker, New York City; Edward Martin, Philadelphia; and John B. Roberts, Chairman, 313 S. 17th Street, Philadelphia, to report on the operative and non-operative of closed and open fractures of the long bones and the value of radiography in the study of these injuries. Surgeons, who have published papers relating to this subject within the last ten years, will confer a favor by sending two reprints to the chairman of the committee. If no reprints are available, the titles and places of their publication are desired.

John B. Roberts, *Chairman*, 313 S. 17th St., Philadelphia, Pa.

Parke, Davis & Co. have forwarded to us copies of the correspondence which passed between them and John Thompson, editor of Pierson's Magazine, anent the subject of an article on Schafer's phylacogens. This correspondence is too long for us to publish in full, but the Parke, Davis Company deplore the publishing of the article by Dorsch which they believe will delay and injure the work which is being done on phylacogens by calling attention of the public to these products before their exact value has been definitely established. The Pierson Company believe that the public are entitled to the story of discoveries, but it must be confessed that it is sometimes difficult for even a physician to state what should and what should not be published that it must be doubly difficult for one who has not been trained in the profession.

#### Correspondence.

TRINITY SANITARIUM, TRINITY, TEXAS, Sept. 7, 1912.

Dr. Charles Emil Brack, Baltimore, Md.

MY DEAR BRACK.—I am enclosing you my check for three dollars to pay some dues to the Alumni Journal. I don't know just how I stand, but you can give me credit for this.

I am still knocking along in the world in a first-rate sort of way; have not done any general practice during the last year, am confining my work to general surgery, have a small sanitarium of my own and just about what work I can do.

I read about the success of our various friends in the Alumni Journal every little while and am always delighted, and I am especially well pleased to see so many of my former class mates and "near" class mates within reach of places on the faculty of our Alma Mater—I am convinced the P. and S. boys are a success wherever they have gone.

I am, sincerely your friend,

FRANK L. BARNES.

LIMAVILLE, OHIO, Nov. 26, 1912.

Dr. Charles E. Brack, Baltimore, Md.

DEAR DR. BRACK.—I am enclosing \$1.00 for next year's Journal. I am always interested in hearing about the college or any of its alumni. I am getting comfortably established here just out of Alliance.

With best wishes to yourself, I am sincerely yours,

James F. Wilson, '09.

Brooklyn, N. Y., Jan. 13, 1913.

MY DEAR DR. BRACK.—I herewith enclose with pleasure check for advance payment of Journal. Are you sure you are forwarding the splendid little publication to above address regularly? It seems to me I am not getting it frequently enough.

I was highly gratified to have met Dr. Harry Friedenwald at the A. M. A. Convention last June at Atlantic City. How I failed to find out about our alumni reunion there is beyond my comprehension; but I felt exceedingly sorry to have missed it, I can assure you.

This is the 20th year that I have been practising in this city, and have no kick coming.

With hearty greetings to the boys, young and old.

Sincerely yours,

М. А. Сони, '93.

WASHINGTON, PA., Dec. 30, 1912.

Dr. Wm. S. Gardner, Baltimore, Md.

MY DEAR DR. GARDNER.—Am enclosing clipping from one of the Chillicothe newspapers which explains itself. The news contained came as a profound and disagreeable shock to me, as Zurcher had visited me a short time ago and seemed to be in the best of health, and I cannot bring myself to a full realization of it as yet. Will you kindly apprise Spearman of the news.

Mrs. Brehmer joins me in wishing Mrs. Gardner and yourself a happy and prosperous New Year.

Very truly yours,

Harrison L. Brehmer.

NEWARK, N. J., Jan. 18, 1913.

MY DEAR DR. BRACK.—Enclosed please find check for \$2.00, my subscription to the JOURNAL for 1912 and 1913.

Please extend my hearty congratulations to our new dean, Dr. Lockwood. With kindest regards to yourself and all my friends, I remain,

Yours sincerely,

JAMES S. HEWSON, '09.

LIBERTY, PA., Jan. 20, 1913.

MY DEAR DR. BRACK.—Enclosed find P. M. O. for \$2.00 for subscription to Alumni Journal for 1912 and 1913. I enjoy reading Journal very much. I am doing a heavy country practice here, but hope to be able in near future to take some post-graduate work and locate in city.

Yours fraternally,

WALTER G. STROBLE.

P. S.—I have spent one month of each fall with Dr. H. W. Johnson, '08, of Wytopitlock, Me., hunting. We have a grand old time, free from all the care and worry of a practitioner of medicine. Dr. Johnson is doing nicely.

#### A POSSIBLE REVOLUTION IN THE TREATMENT OF INFECTIOUS DISEASE.

Are existing methods of treating bacterial diseases to be fundamentally changed? Do the Phylacogens furnish the key to a new and enlightened therapy? Medical and other scientific men are beginning to ask these questions. Less than one year ago the name Phylacogen had not been injected into the language. To-day you can scarcely pick up an American medical journal that does not contain some reference to the remarkable group of products for which it stands.

What are Phylacogens? Briefly, they are sterile aqueous solutions of metabolic substances generated by bacteria grown in artificial media. The name Phylacogen (from the Greek) means "phylaxin-producer"—literally, "a guard" and "to produce."

The initial Phylacogens were originated by Dr. A. F. Schafer in 1908, the method of preparation and technique of application being first presented to the San Joaquin Medical Society in Fresno, California, in October, 1910, and later to the San Francisco Medical Society (January 14, 1911). Subsequently the preparation of the Phylacogens was entrusted to Parke, Davis & Co., the work of manufacture being carried on at the company's biological laboratories in Detroit, Michigan.

The principle upon which the use of the Phylacogens is founded is the theory of multiple infections. Three facts are set forth as the basis of the new therapy:

- 1. Practically all acute and many chronic diseases are caused by the metabolic products of bacteria.
- 2. The human subject is the host of micro-organisms that are pathologically latent, but capable of setting up a disease process under certain conditions.
- 3. The growth of infecting micro-organisms can be arrested and their effects neutralized by products derived from their development in artificial culture media.

Five Phylacogens are now available: Rheumatism Phylacogen, Erysipelas Phylacogen, Gonorrhea Phylacogen, Pneumonia Phylacogen, and Mixed Infection Phylacogen (the last named being applicable to the multiplicity of infections which may be said to be of questionable etiology). They are supplied in rubber-stoppered glass bulbs of 10 cc. capacity and are administered hypodermically (subcutaneously or intravenously).

Many experienced physicians, representing both private and hospital practice, believe that in the Phylacogens we have the most efficient remedial agents yet devised for the treatment of acute and chronic infections.

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